

<i>SERFF Tracking Number:</i>	<i>RDWS-125918448</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Wichita National Life Insurance Co.</i>	<i>State Tracking Number:</i>	<i>40991</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>L07I Individual Life - Whole</i>	<i>Sub-TOI:</i>	<i>L07I.101 Fixed/Indeterminate Premium - Single Life</i>
<i>Product Name:</i>	<i>Whole Life</i>		
<i>Project Name/Number:</i>	<i>Wichita National Whole Life-LWL (01/09)/</i>		

Filing at a Glance

Company: Wichita National Life Insurance Co.

Product Name: Whole Life

TOI: L07I Individual Life - Whole

Sub-TOI: L07I.101 Fixed/Indeterminate

Premium - Single Life

Filing Type: Form

SERFF Tr Num: RDWS-125918448 State: ArkansasLH

SERFF Status: Closed

Co Tr Num:

Co Status:

Author: Judy Tait

Date Submitted: 12/02/2008

State Tr Num: 40991

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 12/16/2008

Disposition Status: Approved

Implementation Date:

Implementation Date Requested: 01/01/2009

State Filing Description:

General Information

Project Name: Wichita National Whole Life-LWL (01/09)

Project Number:

Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments: Form is currently being submitted to state of domicile (Oklahoma).

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 12/16/2008

State Status Changed: 12/16/2008

Corresponding Filing Tracking Number:

Filing Description:

Wichita National Life Insurance Co.

LWL (01-09)

Level Amount Whole Life Insurance

Level Premiums Payable to Specified Age or Until Prior Death of Insured

Market Type: Individual

Group Market Size:

Group Market Type:

Deemer Date:

SERFF Tracking Number: RDWS-125918448 State: Arkansas
Filing Company: Wichita National Life Insurance Co. State Tracking Number: 40991
Company Tracking Number:
TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life

Product Name: Whole Life
Project Name/Number: Wichita National Whole Life-LWL (01/09)/

Face Amount Payable at Death
Non-Participating

Company and Contact

Filing Contact Information

(This filing was made by a third party - ruddandwisdominc)

Judy Tait, Admin jtait@ruddwisdom.com
Rudd and Wisdom, Inc. (512) 346-1590 [Phone]
Austin, TX 78759 (512) 345-7437[FAX]

Filing Company Information

Wichita National Life Insurance Co.	CoCode: 70548	State of Domicile: Oklahoma
711 D Avenue	Group Code:	Company Type: LAH
Lawton, OK 73501	Group Name:	State ID Number:
(580) 353-5776 ext. [Phone]	FEIN Number: 73-0662117	

Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

CHECK NUMBER	CHECK AMOUNT	CHECK DATE
16499	\$50.00	11/26/2008

SERFF Tracking Number:	RDWS-125918448	State:	Arkansas
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TOI:	L071 Individual Life - Whole	Sub-TOI:	L071.101 Fixed/Indeterminate Premium - Single Life
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	12/16/2008	12/16/2008

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Linda Bird	12/09/2008	12/09/2008	Judy Tait	12/16/2008	12/16/2008
Pending Industry Response	Linda Bird	12/09/2008	12/09/2008	Judy Tait	12/16/2008	12/16/2008

Amendments

Item	Schedule	Created By	Created On	Date Submitted
Application	Supporting Document	Judy Tait	12/16/2008	12/16/2008

<i>SERFF Tracking Number:</i>	<i>RDWS-125918448</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Wichita National Life Insurance Co.</i>	<i>State Tracking Number:</i>	<i>40991</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>L071 Individual Life - Whole</i>	<i>Sub-TOI:</i>	<i>L071.101 Fixed/Indeterminate Premium - Single Life</i>
<i>Product Name:</i>	<i>Whole Life</i>		
<i>Project Name/Number:</i>	<i>Wichita National Whole Life-LWL (01/09)/</i>		

Disposition

Disposition Date: 12/16/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: RDWS-125918448 State: Arkansas

Filing Company: Wichita National Life Insurance Co. State Tracking Number: 40991

Company Tracking Number:

TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life

Product Name: Whole Life

Project Name/Number: Wichita National Whole Life-LWL (01/09)/

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document (revised)	Application		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Third party authorization to file forms		Yes
Supporting Document	Certification		Yes
Form (revised)	Whole Life Form		Yes
Form	Whole Life Form		Yes

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Company Tracking Number:
TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
Product Name: Whole Life
Project Name/Number: Wichita National Whole Life-LWL (01/09)/

Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 12/09/2008
Submitted Date 12/09/2008
Respond By Date

Dear Judy Tait,

This will acknowledge receipt of the captioned filing.

Objection 1

- Certification/Notice (Supporting Document)

Comment: Ark. Code Ann. 23-79-138 requires that certain information accompany every policy. Bulletin 6-87 and Bulletin 11-88 further address this issue. Please review your issue procedures and assure us that you are in compliance with Ark. Code Ann. 23-79-138 as provided by these bulletins.

Regulation 19s10B requires that all new or revised filings submitted must contain a certification that the submission meets the provisions of this rule as well as all applicable requirements of this Department.

Please feel free to contact me if you have questions.

Sincerely,

Linda Bird

Response Letter

Response Letter Status Submitted to State
Response Letter Date 12/16/2008
Submitted Date 12/16/2008

Dear Linda Bird,

Comments:

Response 1

Comments: Attached is a certification from the actuary, Chris McCaul, to address the issue raised in this objection.

Related Objection 1

SERFF Tracking Number: RDWS-125918448 State: Arkansas
Filing Company: Wichita National Life Insurance Co. State Tracking Number: 40991
Company Tracking Number:
TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
Product Name: Whole Life
Project Name/Number: Wichita National Whole Life-LWL (01/09)/

Applies To:

- Certification/Notice (Supporting Document)

Comment:

Ark. Code Ann. 23-79-138 requires that certain information accompany every policy. Bulletin 6-87 and Bulletin 11-88 further address this issue. Please review your issue procedures and assure us that you are in compliance with Ark. Code Ann. 23-79-138 as provided by these bulletins.

Regulation 19s10B requires that all new or revised filings submitted must contain a certification that the submission meets the provisions of this rule as well as all applicable requirements of this Department.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Certification

Comment: Attached is a certification from the actuary, Chris McCaul, to address the issue raised in this objection.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,
Judy Tait

SERFF Tracking Number: RDWS-125918448 State: Arkansas
Filing Company: Wichita National Life Insurance Co. State Tracking Number: 40991
Company Tracking Number:
TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
Product Name: Whole Life
Project Name/Number: Wichita National Whole Life-LWL (01/09)/

Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 12/09/2008
Submitted Date 12/09/2008
Respond By Date
Dear Judy Tait,

This will acknowledge receipt of the captioned filing.

Objection 1

- Whole Life Form (Form)

Comment: Ark. Code Ann. 23-79-116 requires that the contract contain facsimile signature of officers.

We find no contract provision for refund of unearned premium as required by Ark. Code Ann. 23-81-118.

Please refer to Interest From Date of Death provision. Ark. Code Ann. 23-81-118 requires an interest rate of 8%.

Please feel free to contact me if you have questions.

Sincerely,

Linda Bird

Response Letter

Response Letter Status Submitted to State
Response Letter Date 12/16/2008
Submitted Date 12/16/2008

Dear Linda Bird,

Comments:

Response 1

Comments: Form NO. LWL (01/09) is being submitted again with changes requested:

1. Facsimile signature of officers on front page;

SERFF Tracking Number: RDWS-125918448 State: Arkansas

Filing Company: Wichita National Life Insurance Co. State Tracking Number: 40991

Company Tracking Number:

TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life

Product Name: Whole Life

Project Name/Number: Wichita National Whole Life-LWL (01/09)/

2. Addition of refund of unearned premium clause on page 7, under Payment of Proceeds, paragraph 2.

Related Objection 1

Applies To:

- Whole Life Form (Form)

Comment:

Ark. Code Ann. 23-79-116 requires that the contract contain facsimile signature of officers.

We find no contract provision for refund of unearned premium as required by Ark. Code Ann. 23-81-118.

Please refer to Interest From Date of Death provision. Ark. Code Ann. 23-81-118 requires an interest rate of 8%.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Whole Life Form	LWL (01-09) AR		Policy/Contract/Fraternal Certificate	Initial		54	LWL(01-09) AR.pdf
Previous Version							
Whole Life Form	LWL (01-09)		Policy/Contract/Fraternal Certificate	Initial		54	LWL(01-09).pdf

No Rate/Rule Schedule items changed.

Sincerely,
Judy Tait

SERFF Tracking Number: RDWS-125918448 *State:* Arkansas
Filing Company: Wichita National Life Insurance Co. *State Tracking Number:* 40991
Company Tracking Number:
TOI: L071 Individual Life - Whole *Sub-TOI:* L071.101 Fixed/Indeterminate Premium - Single Life
Product Name: Whole Life
Project Name/Number: Wichita National Whole Life-LWL (01/09)/

Amendment Letter

Amendment Date:

Submitted Date: 12/16/2008

Comments:

Please replace the previously approved applications originally submitted with this filing - APP-1 (11/97) and APP-2 (11/97) with APP-1 (12/08) and APP-2 (12/08).

The difference in the applications is that we have added a statement to the Authorization stating that it is valide for 24 months and can be revoked at any time and describes the procedure to do so.

Thank you.

Changed Items:

Supporting Document Schedule Item Changes:

Satisfied -Name: Application

Comment: Form will be used with submitted applications as follows:

APP-1 (12/08)

APP-2 (12/08)

App 1 D10.pdf

app 2 D10.pdf

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Product Name: Whole Life

Project Name/Number: Wichita National Whole Life-LWL (01/09)/

Form Schedule

Lead Form Number: LWL (01-09)

Review Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	LWL (01-09) AR	Policy/Cont Whole Life Form ract/Fratern al Certificate	Initial		54	LWL(01-09) AR.pdf

WICHITA NATIONAL LIFE INSURANCE COMPANY

Wichita National Building • 711 S.W. "D" Avenue • Lawton, Oklahoma 73501 • 580-353-5776

A Legal Reserve Capital Stock Company
(Hereafter called: we, our or us).

We Agree

- To pay the insurance benefits of this policy to the beneficiary upon receiving due proof of the insured's death, and
- To provide you with the other rights and benefits of this policy.

These agreements are subject to the provision of this policy.

10 Day Free Look

If for any reason you are not satisfied with your policy, you may cancel it by returning the policy to us or to your agent within 10 days after you receive it. If you do, we will refund the premium that was paid.

Signed for us at our home office



SECRETARY



PRESIDENT

Level Amount Whole Life Insurance
Level Premiums Payable to Specified Age or Until Prior Death of Insured
Face Amount Payable at Death
Non-Participating

DEFINITIONS

When we use the following words, this is what we mean:

THE INSURED

The person whose life is insured under this policy as shown on page 3.

YOU, YOUR

The owner of this policy is as shown in the application, unless subsequently changed as provided for in this policy. The owner is the insured unless otherwise stated.

BENEFICIARY

The person to receive the proceeds in the event of the insured's death.

POLICY DATE

The date coverage under this policy becomes effective and the date from which policy anniversaries, policy years, policy months and premium due dates are determined.

POLICY ANNIVERSARY

The same day and month as your policy date for each succeeding year your policy remains in force.

WRITTEN REQUEST

A request in writing signed by you on a form agreeable to us. We also may require that your policy be sent in with your written request.

PROCEEDS

The amount we are obligated to pay under the terms of this policy when your policy is surrendered, matures, or when the insured dies.

IN FORCE

The period of time the insured's life remains insured under the terms of this policy.

LAPSE OR LAPSED

A premium is in default, and the insured's life is no longer insured under the terms of this policy except as may be provided for in the Guaranteed Value Options section (see page 6).

REINSTATE

To restore coverage after the policy has lapsed.

TERMINATE

The insured's life is no longer insured under any of the terms of this policy.

INDEBTEDNESS

All policy and premium loans, accrued interest and any due and unpaid premium.

AGE

The insured's age at the insured's last birthday, unless we state otherwise.

POLICY SPECIFICATIONS PAGE

TYPE OF COVERAGE	AMOUNT	PREMIUM PAYABLE	ANNUAL PREMIUM
[Whole Life]	[\$25,000]	[for Life]	[\$354.00]

Total Annual Premium on Policy Date

The Premiums for a benefit are payable for the lifetime of the insured, the first due on the Policy Date.

SCHEDULE OF TOTAL PREMIUMS

Annual	Semi-Annual	Quarterly	Monthly
[\$354.00]	[\$184.08]	[\$92.04]	[\$92.04]

PREMIUM CLASS:

POLICY LOAN INTEREST RATE: 7.4% per annum, or less. We may change the interest rate, but never will it exceed 7.4%. We will give written notice of the change to you or any assignee of record at least 30 days before the change becomes effective. Interest is payable at the end of the policy year.

REINSTATEMENT INTEREST RATE: 6% per annum

POLICY NUMBER: [12345W]

FACE AMOUNT: [\$25,000]

AGE / SEX: [35 Male]

INSURED: [John Doe]

POLICY DATE: [January 1, 2009]

POLICY SPECIFICATIONS

The values in the following table assume that all premiums are paid when due and no policy loans are taken. Policy values not illustrated will be furnished upon request.

End of Policy Year	Amount of Insurance	Cash Value	Reduced Paid Up	Extended Term Insurance	
				Years	Days
1	[25,000]	[0]	[0]	[0]	[0]
2	[25,000]	[0]	[0]	[0]	[0]
3	[25,000]	[200]	[875]	[5]	[64]
4	[25,000]	[450]	[1,875]	[9]	[187]
5	[25,000]	[725]	[2,925]	[13]	[64]
6	[25,000]	[1,000]	[3,875]	[15]	[234]
7	[25,000]	[1,300]	[4,875]	[17]	[229]
8	[25,000]	[1,600]	[5,800]	[19]	[33]
9	[25,000]	[1,900]	[6,650]	[20]	[38]
10	[25,000]	[2,225]	[7,525]	[20]	[356]
11	[25,000]	[2,550]	[8,350]	[21]	[227]
12	[25,000]	[2,875]	[9,100]	[22]	[39]
13	[25,000]	[3,200]	[9,800]	[22]	[161]
14	[25,000]	[3,550]	[10,525]	[22]	[272]
15	[25,000]	[3,925]	[11,275]	[23]	[0]
16	[25,000]	[4,300]	[11,950]	[23]	[45]
17	[25,000]	[4,675]	[12,600]	[23]	[53]
18	[25,000]	[5,050]	[13,175]	[23]	[31]
19	[25,000]	[5,450]	[13,775]	[23]	[11]
20	[25,000]	[5,850]	[14,350]	[22]	[329]
Age 60	[25,000]	[7,950]	[16,825]	[21]	[246]
Age 65	[25,000]	[10,175]	[18,800]	[19]	[303]
Age 70	[25,000]	[12,450]	[20,375]	[17]	[229]

The cash values, reduced paid up extended term values are based upon the [2001 Commissioners Standard Ordinary] mortality table, age last birthday and an annual interest rate of [4.0%]. The reserves are calculated based on the [2001 Commissioners Standard Ordinary] mortality table, age last birthday and an annual interest rate of [4.0%]. Premiums are payable for life.

GENERAL INFORMATION

THE CONTRACT

Your policy is issued in consideration of the application and the payment of premiums as provided for in this policy.

Your policy and the copy of the application attached to it contains the entire contract between you and us. Any statements made in the application either by you or by the insured will, in the absence of fraud, be considered representations and not warranties. Also, any written statements made either by you or by the insured will not be used to void your policy nor defend against a claim under your policy unless the statement is contained in the application.

No change or waiver of any of the provisions of this policy will be valid unless made in writing by us and signed by our president, a vice president, our secretary or an officer of the company. No agent or other person has the authority to change or waive any provision of your policy.

Any extra benefit rider attached to this policy will become a part of this policy and will be subject to all the terms and conditions of this policy unless we state otherwise in the rider.

SUICIDE

If the insured, whether sane or insane, dies by suicide, within two years from the policy date, our liability will be limited to an amount equal to the premiums paid for this policy.

INCONTESTABILITY

We cannot contest this policy after it has been in force during the lifetime of the insured for two years after the policy date, except for non-payment of premiums.

COLLATERAL ASSIGNMENT

Your policy may be assigned. The assignment must be in writing and filed at our home office. We assume no responsibility for the validity or effect of any assignment of this policy or of any interest in it. Any proceeds which become payable to an assignee will be payable in a single sum. Any claim made by an assignee will be subject to proof of the assignee's interest and the extent of the assignment.

MISSTATEMENT OF AGE OR SEX

If the age or sex of the insured has been misstated, the benefits will be those which the premiums paid would have purchased for the correct age and sex.

BENEFICIARY

When we receive proof satisfactory to us of the insured's death, we will pay the death proceeds of this policy to the beneficiary or beneficiaries who are named in the application for this policy unless you subsequently change the beneficiary. In that event, we will pay the death proceeds to the beneficiary named in your last change of beneficiary request as provided for in this policy.

If a beneficiary dies before the insured, that beneficiary's interest in this policy ends with that beneficiary's death. Only those beneficiaries who survive the insured will be eligible to share in the death proceeds. If no beneficiary survives the insured, we will pay the death proceeds of this policy to your estate.

CHANGE OF OWNER OR BENEFICIARY

If you have reserved the right to change the owner or beneficiary, you can file a written request with us to make such a change. If you have not reserved the right to change the beneficiary, the written consent of the irrevocable beneficiary will be required.

Your written request will not be effective until it is recorded in our home office records. After it has been so recorded, it will take effect as of the date you signed the request. However, if the insured dies before the request has been so recorded, the request will not be effective as to those death proceeds we have paid.

CHANGE OF PLAN

While your policy is in force with no premium in default, you may exchange your policy for another form of policy. Our approval is needed. An additional payment and evidence that the insured is then insurable under our underwriting rules then in effect, may be required.

PREMIUMS

Your first premium is due as of the policy date and must be paid when the application for insurance is completed. All premiums after the First premium are payable on or before the date they are due and must be mailed to us at our home office. If you would like a receipt for a Premium payment we will give you one upon request.

The premiums for your policy are payable for the period shown on page 3 of your policy, or until the prior death of the insured.

PAYMENT INTERVALS

You may pay your premiums at any interval shown on page 3. These premiums are shown as annual (once a year), semi-annual (twice a year), quarterly (four times a year) or monthly (twelve times a year). You may change the frequency of premium payments, subject to our rules in effect at the time of the change, by filing a written request with us at our home office.

GRACE PERIOD

Your policy has a 31-day grace period. This means that if a premium is not paid on or before the date it is due, you may pay that premium during the 31-day period immediately following the due date. Your premium payment, however, must be received in our home office within the 31-day period. The insured's life will continue to be insured during this 31-day period.

If the insured dies during this period, we will deduct a premium for the 31-day grace period from the death proceeds of this policy. This 31-day grace period does not apply to the first premium payment.

The first premium payment must be paid when your application is completed.

NON-PAYMENT OF PREMIUMS

If a premium is not paid by the end of the grace period, the policy will lapse as of the premium due date and be out of force except as provided in the Guaranteed Value Options provision (see page 6).

REINSTATEMENT

If a premium is not paid before the end of the 31-day grace period, your policy will lapse, and no further premium payments may be made.

However, even if your policy lapses, the values provided for in the Guaranteed Value Options section of this policy on page 6 may be available to you. You may also ask us within five years of lapse to restore your policy to a premium paying basis. We will require:

1. Your written request to reinstate this policy.
2. Evidence of insurability satisfactory to us.
3. Payment of any indebtedness.

4. Payment of all past due premiums on your policy, and
5. Payment of interest compounded annually on all past due premiums and any indebtedness. The policy reinstatement interest rate will be the rate shown on page 3.

Our determination of the insured's continued insurability and the payment of all past due premiums with interest must occur during the insured's lifetime. Your policy cannot be reinstated if your policy was placed on extended term insurance and the term period has expired or if your policy was surrendered for cash.

We may contest the reinstatement of this policy until it has been in force during the lifetime of the insured for two years from the date of reinstatement.

YOUR LOAN VALUES

Your policy has two loan privileges:

1. You may borrow the cash value.
2. You may have past due premiums paid by automatic loans.

Loans have priority over the claims of any assignee or other person. Your policy is the sole security for all loans.

POLICY LOANS

You can borrow up to the available loan value of your policy unless your policy is on extended term or reduced paid-up insurance (see below). At Your request, we will send you a loan agreement for your signature. We have the right to postpone your loan for up to six months unless the loan is to be used to pay premiums on any policies you have with us.

The loan value of your policy is its cash value (see page 4) minus any indebtedness. Your cash value will be determined as of the date to which your premiums are paid on this policy, but not beyond the next policy anniversary.

AUTOMATIC PREMIUM LOANS

If you asked for this service in your application, or by later written request, we will automatically make a loan to you to pay any premium not paid by the end of the grace period. Your policy

must be in force and have enough loan value. If there is not enough loan value to pay a premium, the policy will lapse and the Guaranteed Value Options provision will apply (see below).

You can also make written request to tell us you do not want this service.

LOAN INTEREST PROVISION

Policy loans will bear interest at the rate specified on page 3.

If you do not pay the interest on your loan when it is due, the unpaid interest will be added to your loan and charged the same rate of interest as your loan.

INDEBTEDNESS

If indebtedness exceeds the cash value of your policy, we will mail notice to your last known address and that of any assignee of record. If the excess is not paid within 31 days, the policy will terminate.

You may repay all or part of the indebtedness while the insured is alive and no Guaranteed Value Option is in effect.

Any outstanding indebtedness at the time of the insured's death will be deducted from policy proceeds.

GUARANTEED VALUE OPTIONS (Non-Forfeiture Options)

Your policy provides Guaranteed Value Options as shown on page 4. You may elect any available option by writing to us.

A premium may be paid in cash or by an automatic premium loan. If a premium is not paid by the end of the grace period, the paid-up insurance option shall become effective as of the due date of the unpaid premium. However, you will still have the right for two months after that due date to elect one of the Guaranteed Value Options.

PAID-UP INSURANCE OPTION

You may continue your policy as paid-up insurance for a reduced amount, payable under the same conditions as this policy. We will use the cash value to buy paid-up insurance at the net single premium rate for the insured's attained age. If a paid-up policy is surrendered for its cash value within 30 days after a policy anniversary, the cash value will be equal to the cash value on that policy anniversary.

EXTENDED TERM INSURANCE OPTION

If this is a standard premium class policy, you may continue it as term insurance. No further premium will be due. The amount of

the extended Term insurance will be the total of:

- The face amount of this policy
- MINUS • Any indebtedness (see definition, page 2).

The term period begins on the date to which premiums are paid. The cash Value is applied as a net single premium at the insured's attained age to determine the length of the term. For this purpose, the attained age will be the insured's age on the date of the first unpaid premium. If a policy on extended term insurance is surrendered for its cash value within 30 days after a policy anniversary, the cash value will be equal to the cash value on that policy anniversary. If an equal or greater amount of insurance would be provided under the paid-up insurance option, only that option will be available.

CASH VALUE OPTION

You may surrender your policy for its cash value. Your cash value is:

- The cash value of your policy (see page 4)
- MINUS • Any indebtedness

Surrender will be effective on the date of your written request. We may require that your policy be sent in with your written request before making surrender payment.

We may defer payment of any cash value for not more than six months.

When you surrender your policy for its cash value your policy will terminate.

BASIS USED FOR CALCULATIONS

We use the mortality table, and interest rate shown on page 4, to calculate (1) cash values, (2) reserves and (3) net single premiums for paid-up insurance.

All values are at least equal to those required by the law of the

state in which the policy is delivered. We have filed with that state a detailed statement of the method of calculating values.

The values shown on page 4 are for completed policy years. They assume that there is no indebtedness and that premiums are paid to the end of the policy year.

After the policy year in which a value is first shown, the values between any two policy years shown will be determined by interpolation with allowance for the premiums paid for the period between such consecutive years. Values for policy years not shown will be furnished upon request.

The cash value of any paid-up insurance is the net single premium for such insurance at the attained age of the insured.

PAYMENT OF PROCEEDS

The proceeds of this policy will be payable if the policy is surrendered for its cash value (living benefits), or when we receive due proof satisfactory to us of the insured's death (death benefits). These events must occur while the policy is in force. The proceeds will be paid in a single sum unless a settlement option has been selected. We will deduct any indebtedness from the proceeds. All payments by us are payable at our home office. Proof of any claim under this policy must be submitted in writing to our home office.

Proceeds payable to the beneficiary shall include premiums paid for any period beyond the end of the policy month in which death occurred. We will pay interest on any unearned premium in the manner and at the interest rate required by law in the state where this Policy was issued.

SETTLEMENT OPTIONS

You may, during the insured's lifetime, request that we pay the proceeds under one of the following settlement options. We will also use any other method of payment that is agreeable to you and us. A settlement option may be selected only if the payments are to be made to a natural person in that person's own right.

OPTION 1--Interest Payments--

(Payment of Interest on the proceeds at such time and for a period that is agreeable to you and us.) Withdrawal of proceeds may be made in amounts of at least \$100. At the end of the period, any remaining proceeds will be paid in either a single sum or under any other method we approve.

OPTION 2--Payments for a Specified Period--

(Monthly payments for a specified number of years) The amount of each monthly payment for each \$1,000 of proceeds applied under this option is shown in the following table. The monthly payments for any period not shown will be furnished upon request.

OPTION 2 TABLE

PAYMENTS FOR A SPECIFIED PERIOD	
Number of Years Payable	Amount of Monthly Payments
5	\$17.91
10	9.61
15	6.87
20	5.51
25	4.71
30	4.18

OPTION 3--Life Income--

(Monthly payments for the life of the person who is to receive the income) We will require satisfactory proof of the person's age and sex. Payments can be guaranteed for 10, 15, or 20 years. The amount of each monthly payment for each \$1,000 of proceeds applied under this option is shown in the following table. The monthly payments for any ages not shown will be furnished upon request.

OPTION 3 TABLE

LIFE INCOME					
MONTHLY INCOME PAYMENTS					
Guaranteed For Life			Guaranteed For For 10 Years		
M	AGE	F	M	AGE	F
\$4.50	50	\$3.98	\$4.41	50	\$3.95
5.09	55	4.44	4.93	55	4.38
5.86	60	5.08	5.56	60	4.95
6.93	65	5.96	6.32	65	5.68
8.43	70	7.22	7.20	70	6.58
Guaranteed For For 15 Years			Guaranteed For For 20 Years		
M	AGE	F	M	AGE	F
\$4.30	50	\$3.90	\$4.14	50	\$3.83
4.73	55	4.30	4.46	55	4.16
5.20	60	4.78	4.77	60	4.52
5.79	65	5.32	5.02	65	4.86
6.14	70	5.87	5.19	70	5.11

OPTION 4--Payments of a Specified Amount--

(Monthly payments of a specified amount until the proceeds and interest are fully paid.)

OPTION 5--Joint and Survivor Life Income--

We will pay the amount retained, with interest, in equal monthly installments during the joint lifetime of two persons and continue them during the lifetime of the survivor. See table below for example. We will furnish the income for other combinations of age or sex, if requested.

OPTION 5 TABLE

JOINT AND SURVIVOR LIFE INCOME				
MONTHLY INSTALLMENTS FOR EACH \$1,000 OF AMOUNT RETAINED				
	AGE OF OTHER PAYEE* (FEMALE)			
	15 Years Less than Male Payee's	10 Years Less than Male Payee's	5 Years Less than Male Payee's	Same as Male Payee's
50	\$3.07	\$3.23	\$3.42	\$3.61
55	3.27	3.48	3.72	3.97
60	3.53	3.80	4.11	4.45
65	3.87	4.23	4.65	5.12
70	4.31	4.80	5.40	6.06
*Age nearest birthday.				

OPTION 6--Alternate Income--

When a type of income option available under Option 2, 3 or 5 is desired, we will automatically pay that type of income under this option if the amount is greater than under Option 2, 3 or 5. The amount of income under this option will be based on actuarial assumptions then being used by us for our single premium immediate annuities. However, there will be a charge for taxes or expenses.

INTEREST FROM DATE OF DEATH

If the proceeds of any benefits under this policy are not paid within thirty days after we receive due proof of the death of the insured (or where required by law within thirty days after the death of the insured), we will pay interest on death benefits from the date of death to the date of payment. The interest rate will be determined by us, but never less than 3%.

CONDITIONS

1. Proceeds of less than \$1,000 may not be applied under any settlement option. We may change the payment frequency if payments under an option become less than \$20.
2. A corporation may receive payments under a life income option only if the payments are based on the life of the insured, or a surviving spouse or dependent of the insured.

If a settlement option is requested, we will prepare an agreement to be signed which will state the terms and conditions under which the payments will be made. This agreement will include a statement regarding the withdrawal value, if any, and to whom any remaining proceeds will be paid following the death of the person receiving the payments.

A beneficiary may select a settlement option only after the insured's death. However, you may provide that the beneficiary will not be permitted to change the settlement option you have selected.

PROCEEDS EXEMPT FROM CLAIM OF CREDITORS

To the extent permitted by law, no payment of proceeds or interest we make will be subject to the claims of any creditors.

Also, if you provide that the option selected cannot be changed after the insured's death, the payments will not be subject to the debts or contracts of the person receiving the payments. If garnishment or any other attachment of the payments is attempted, we will make those payments to a trustee we name. The trustee will apply those payments for the maintenance and support of the person you named to receive the payments.

RATE OF INTEREST

Options 1, 2 and 4 are based on a guaranteed interest rate of 3%. Options 3, 5 and 6 are based on a guaranteed interest rate of 2.5% using the 1949 Annuity Mortality Table.

SUMMARY OF POLICY BENEFITS

LIVING BENEFITS

Your policy has certain guaranteed values which are available to you during your lifetime. These values consist of the cash or loan values. You may use these values:

- To provide retirement income (see page 7).
- As collateral for a loan or as the basis for a policy loan (see page 6)
- To continue some insurance protection if you cannot or do not wish to continue paying premiums (see page 6).
- To obtain cash by surrendering your policy (see page 6).

The available cash or loan value for such users is the total of:

- | | |
|-------|--|
| MINUS | <ul style="list-style-type: none"> • The cash value of your policy (see page 4) • Any indebtedness (see definition page 2) |
|-------|--|

DEATH BENEFITS

The amount of payment to the beneficiary is the total of the following amounts determined on the date of the insured's death:

- | | |
|-------|---|
| PLUS | <ul style="list-style-type: none"> • The face amount of this policy (see page 3) • Any additional insurance on the insured's life provided by an extra benefit rider (see page 3) |
| MINUS | <ul style="list-style-type: none"> • Any indebtedness (see definition, page 2). |

EXTRA BENEFIT RIDERS

The extra benefits, if any, listed on page 3 are fully described in the extra benefit riders that immediately precede the copy of your application.

YOUR RIGHTS

During the insured's lifetime and unless otherwise provided in this policy, you have the exclusive right to assign this policy, to receive every benefit and to exercise every right, privilege and option this policy grants or that we allow. Among your rights are:

- To change the owner or beneficiary. (Change of Owner and Beneficiary, page 5.)
- To surrender this policy. (Cash Value Option, page 6.)
- To stop premium payments but keep part of the face amount in force for the full period of the policy. (Paid-Up Insurance, page 6)
- To change the frequency of premium payments. (Payment Intervals, page 5.)

- To use the loan value of the policy to pay premiums due. (Automatic Premium Loan, Page 6.)
- To borrow on the policy. (Policy Loans, page 6.)
- To reinstate the policy after lapse. (Reinstatement, page 6)
- To receive policy benefits as income. (Settlement Options, page 7)

To exercise any of these rights, or to apply for the proceeds or any benefits under this policy, communicate with our nearest representative or directly with our home office. Please notify us promptly of any change of address.

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■ Please examine your policy and the attached copy of the application carefully. Contact your agent if you desire additional service or information.

■ If you change your address, please notify us at the home office giving your full name and policy number

■ Your policy is a valuable asset. For your own protection, let us advise you regarding any suggestion to terminate or exchange this policy.

WICHITA NATIONAL LIFE INSURANCE COMPANY

Wichita National Building
711 S.W. "D" Avenue
Lawton, Oklahoma 73501
580-353-5776

Level Amount Whole Life Insurance
Level Premiums Payable to Specified Age or Until Prior Death of Insured
Face Amount Payable at Death
Non-Participating

Register of Assignment

NOTE --- Assignment Takes Effect **Only** Upon Endorsement By An Executive Officer Of The Company.

DATE ENDORSED	ASSIGNEE	ENDORSED BY
---------------	----------	-------------

<i>SERFF Tracking Number:</i>	<i>RDWS-125918448</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Wichita National Life Insurance Co.</i>	<i>State Tracking Number:</i>	<i>40991</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>L071 Individual Life - Whole</i>	<i>Sub-TOI:</i>	<i>L071.101 Fixed/Indeterminate Premium - Single Life</i>
<i>Product Name:</i>	<i>Whole Life</i>		
<i>Project Name/Number:</i>	<i>Wichita National Whole Life-LWL (01/09)/</i>		

Rate Information

Rate data does NOT apply to filing.

<i>SERFF Tracking Number:</i>	<i>RDWS-125918448</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Wichita National Life Insurance Co.</i>	<i>State Tracking Number:</i>	<i>40991</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>L071 Individual Life - Whole</i>	<i>Sub-TOI:</i>	<i>L071.101 Fixed/Indeterminate Premium - Single Life</i>
<i>Product Name:</i>	<i>Whole Life</i>		
<i>Project Name/Number:</i>	<i>Wichita National Whole Life-LWL (01/09)/</i>		

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice 11/24/2008

Comments:

Attachments:

Guaranty.pdf
LWL Flesch.pdf

Review Status:

Satisfied -Name: Application 12/16/2008

Comments:

Form will be used with submitted applications as follows:

APP-1 (12/08)

APP-2 (12/08)

Attachments:

App 1 D10.pdf
app 2 D10.pdf

Review Status:

Satisfied -Name: Third party authorization to file forms 12/02/2008

Comments:

Attachment:

Wichita authorization to file.pdf

Review Status:

Satisfied -Name: Certification 12/16/2008

Comments:

Attached is a certification from the actuary, Chris McCaul, to address the issue raised in this objection.

Attachment:

LWL Ark cert.pdf

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND DISABILITY INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or disability insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Disability Insurance Guaranty Association (“Guaranty Association”). The purpose of the Guaranty is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers’ care in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Disability Insurance Guaranty Association (“Guaranty Association”) may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life and variable annuity contract.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Disability
Insurance Guaranty Association
c/o The Liquidation Division
1200 West Third Street (Third and Cross)
Little Rock, Arkansas 72201-1904

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Disability Insurance Guaranty Association Act (“Act”). Below is a brief summary of the Act’s coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone’s rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or disability insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;

- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 – no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the Association will not pay more than \$100,000 in health insurance benefits, \$100,000 in present value of annuity benefits, or \$100,000 in life insurance death benefits or cash surrender values – again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

FLESCH READABILITY SCORE CERTIFICATION

WICHITA NATIONAL LIFE INSURANCE COMPANY

I, Chris McCaul, am a consulting actuary doing work for Wichita Life Insurance Company. I certify that the following form has been tested and meets the minimum required reading ease score.

Form Number

Flesch Score

LWL (01/09)

54

11/25/08
Date


Chris McCaul
Rudd and Wisdom, Inc.

APP 1 Use this application for all risks UNDER \$100,000

WICHITA NATIONAL LIFE INSURANCE COMPANY

711 SW D Avenue • P. O. Box 1709 • Lawton, OK. 73502

AMOUNT APPLIED FOR _____
PREMIUM _____

APPLICATION FOR:

☐ Single Life — One Person Insured

☐ Mortgage Protection

☐ Joint Life — Two Persons Insured
(Both must complete, date & sign the application)

☐ Whole Life

☐ Annual Renewable Term

☐ Level Term Protection

☐ Automatic Premium Loan

☐ Rider _____

NAME OF FIRST
PROPOSED
INSURED _____

ADDRESS _____

CITY, STATE, ZIP _____

SOCIAL SECURITY NUMBER _____

PRIMARY
BENEFICIARY
& RELATIONSHIP _____

CONTINGENT
BENEFICIARY
& RELATIONSHIP _____

OWNER IF
NOT PROPOSED
INSURED _____

MODE OF PAYMENT				
ANNUAL	SEMI ANNUAL	QUARTERLY	MONTHLY	BANK DRAFT
OFFICE USE ONLY				
CWA <input type="checkbox"/> Y <input type="checkbox"/> N	POLICY #	AGENT #	PLAN #	TERM

NAME OF SECOND
PROPOSED
INSURED _____

ADDRESS _____

CITY, STATE, ZIP _____

SOCIAL SECURITY NUMBER _____

PRIMARY
BENEFICIARY
& RELATIONSHIP _____

CONTINGENT
BENEFICIARY
& RELATIONSHIP _____

OWNER IF
NOT PROPOSED
INSURED _____

INSURED	DATE OF BIRTH	AGE	STATE OF BIRTH	HEIGHT	WEIGHT	SEX	OCCUPATION	HOME PHONE	WORK PHONE
FIRST									
SECOND									

IF NOT ACTIVELY WORKING, PLEASE EXPLAIN _____

- Have you ever been told you have or have you been treated for any of the following disorders or diseases: cancer, epilepsy, heart attack, heart murmur, irregular heartbeat or any other heart defect, high blood pressure, diabetes, circulatory disease, nervous or mental disorder or disorder of the brain, nervous system, liver, kidney, lung or respiratory disease?
- Within the last 5 years have you consulted, been examined or treated by a physician or have you been under observation or treated at a clinic, hospital or sanitarium or have you ever been rated or declined for life insurance?
- Have you ever used or been treated for the use of illegal drugs or ever received treatment for or joined an organization for alcoholism or alcohol abuse?
- Do you know of any impairment, disease or disorder now existing in your health or mental condition for which you have not seen a physician?
- Have you ever been told you have or have you been treated for an immune deficiency disorder, AIDS the AIDS related complex (ARC) or tested positive for the AIDS virus?
- Have you used tobacco during the past twelve (12) months?
- Has any insurance been cancelled, or the renewal or reinstatement been refused?

FIRST INSURED		SECOND INSURED	
<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO

COMPLETE IF ANY QUESTION ABOVE MARKED YES (ADDITIONAL SPACE ON REVERSE SIDE.)

QUESTIONS NUMBER	INSURED	DETAILS	FROM	DATES TO	RESULTS INCLUDING TREATMENT IF ANY	NAME & ADDRESS OF DOCTOR AN DATE OF LAST VISIT

WARNING: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

I/we hereby declare that to the best of my/our knowledge and belief the above statements and answers to the above questions are complete and true. I/we agree that this application, any amendment thereto, and any added declaration thereto, shall become a part of the policy herein applied for. Application is hereby made for insurance on the life(s) of the proposed insured(s). It is understood that the Company shall incur no liability because of this application unless it is approved by the Company, and the first premium is paid while the health and other conditions affecting the insurability of the proposed insured(s) are as described in this application.

Authorization: "I/we hereby authorize any licensed doctor, or medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution, or person that has any records or knowledge of me (us) or my (our) health to give the Company, or its reinsurer(s) any such information. **NOTICE:** Information authorized for release may include information on physicals, drug, alcohol, communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, HIV/AIDS (Human Immune Deficiency Virus / Acquired Immune Deficiency Syndrome), or other conditions for which I may have been treated while a patient here. I/we acknowledge receipt of the notification form issued in compliance with the Fair Credit Reporting Act and the rules of the Medical Information Bureau.

This authorization and/or photocopy of it shall be valid for a period of twenty-four (24) months after the date it is signed. I understand I can revoke this authorization at any time by submitting a written request to the Company at its Home Office.

First Insured's Signature

Second Insured's Signature

Agent's Signature

Date

REQUIRED NOTICE TO APPLICANT

Details & Remarks: _____

Home Office Endorsements:

ASSIGNMENT

I/WE hereby assign to _____, assignee, the proceeds due to become due under the life insurance policy hereby applied for when issued to the extent of any indebtedness due by me/us to said assignee. I/WE agree that in the event of any default Assignee is authorized to cancel this insurance and credit any premium refund toward my indebtedness as his interest may appear. I also agree that this assignment is irrevocable until all indebtedness due Assignee by me/us has been paid in full and that the rights and interest of any beneficiary under said policy are subordinate to the rights and interest of the Assignee.

Signed at _____ this _____ day of _____ 20 _____.

First Insured

The foregoing assignment is filed at the Company's Home Office this

_____ day of _____, 20 _____.

Policy # _____
Wichita National Life Insurance Company

Who is to pay premium? ☐ Insured ☐ Assignee

AGENT'S CERTIFICATION: I certify that I have personally asked the applicant all of the above questions. I have accurately recorded the facts supplied by the applicant. Pre-notice of the Medical Information Bureau and Fair Credit Reporting Act was given to the applicant prior to completing this application.

Do you have reason to believe that replacement of any existing insurance or annuity may be involved?

☐ YES ☐ NO (if "Yes," explain in "Details and Remarks.")

_____ CASH RECEIVED WITH APPLICATION: LIFE:\$ _____

Soliciting Agent

AGENT INSTRUCTIONS — REMEMBER, GOOD INSTRUCTIONS = FAST ISSUE.

Procedures For Completing This Life Application — When Applying For:

Complete all questions.

- A. The applicant's signature should be obtained on all life applications.
- B. Be sure that required forms are submitted when disclosure is required with life applications, and that all required forms are completed and submitted.
- C. Under "AGENT'S CERTIFICATION," be sure to sign your name on the application, and also submit with the application all forms required when a replacement is involved.

APP 1 Use this application for all risks UNDER \$100,000

WICHITA NATIONAL LIFE INSURANCE COMPANY

711 SW D Avenue • P. O. Box 1709 • Lawton, OK. 73502

AMOUNT APPLIED FOR _____
PREMIUM _____

APPLICATION FOR:

☐ Single Life — One Person Insured

☐ Mortgage Protection

☐ Joint Life — Two Persons Insured
(Both must complete, date & sign the application)

☐ Whole Life

☐ Annual Renewable Term

☐ Level Term Protection

☐ Automatic Premium Loan

☐ Rider _____

NAME OF FIRST
PROPOSED
INSURED _____

ADDRESS _____

CITY, STATE, ZIP _____

SOCIAL SECURITY NUMBER _____

PRIMARY
BENEFICIARY
& RELATIONSHIP _____

CONTINGENT
BENEFICIARY
& RELATIONSHIP _____

OWNER IF
NOT PROPOSED
INSURED _____

MODE OF PAYMENT				
ANNUAL	SEMI ANNUAL	QUARTERLY	MONTHLY	BANK DRAFT

OFFICE USE ONLY				
CWA <input type="checkbox"/> Y <input type="checkbox"/> N	POLICY #	AGENT #	PLAN #	TERM

NAME OF SECOND
PROPOSED
INSURED _____

ADDRESS _____

CITY, STATE, ZIP _____

SOCIAL SECURITY NUMBER _____

PRIMARY
BENEFICIARY
& RELATIONSHIP _____

CONTINGENT
BENEFICIARY
& RELATIONSHIP _____

OWNER IF
NOT PROPOSED
INSURED _____

INSURED	DATE OF BIRTH	AGE	STATE OF BIRTH	HEIGHT	WEIGHT	SEX	OCCUPATION	HOME PHONE	WORK PHONE
FIRST									
SECOND									

IF NOT ACTIVELY WORKING, PLEASE EXPLAIN _____

- Have you ever been told you have or have you been treated for any of the following disorders or diseases: cancer, epilepsy, heart attack, heart murmur, irregular heartbeat or any other heart defect, high blood pressure, diabetes, circulatory disease, nervous or mental disorder or disorder of the brain, nervous system, liver, kidney, lung or respiratory disease?
- Within the last 5 years have you consulted, been examined or treated by a physician or have you been under observation or treated at a clinic, hospital or sanitarium or have you ever been rated or declined for life insurance?
- Have you ever used or been treated for the use of illegal drugs or ever received treatment for or joined an organization for alcoholism or alcohol abuse?
- Do you know of any impairment, disease or disorder now existing in your health or mental condition for which you have not seen a physician?
- Have you ever been told you have or have you been treated for an immune deficiency disorder, AIDS the AIDS related complex (ARC) or tested positive for the AIDS virus?
- Have you used tobacco during the past twelve (12) months?
- Has any insurance been cancelled, or the renewal or reinstatement been refused?

FIRST INSURED		SECOND INSURED	
<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO

COMPLETE IF ANY QUESTION ABOVE MARKED YES (ADDITIONAL SPACE ON REVERSE SIDE.)

QUESTIONS NUMBER	INSURED	DETAILS	FROM	DATES	TO	RESULTS INCLUDING TREATMENT IF ANY	NAME & ADDRESS OF DOCTOR AN DATE OF LAST VISIT

WARNING: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

I/we hereby declare that to the best of my/our knowledge and belief the above statements and answers to the above questions are complete and true. I/we agree that this application, any amendment thereto, and any added declaration thereto, shall become a part of the policy herein applied for. Application is hereby made for insurance on the life(s) of the proposed insured(s). It is understood that the Company shall incur no liability because of this application unless it is approved by the Company, and the first premium is paid while the health and other conditions affecting the insurability of the proposed insured(s) are as described in this application.

Authorization: "I/we hereby authorize any licensed doctor, or medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution, or person that has any records or knowledge of me (us) or my (our) health to give the Company, or its reinsurer(s) any such information. **NOTICE:** Information authorized for release may include information on physicals, drug, alcohol, communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, HIV/AIDS (Human Immune Deficiency Virus / Acquired Immune Deficiency Syndrome), or other conditions for which I may have been treated while a patient here. I/we acknowledge receipt of the notification form issued in compliance with the Fair Credit Reporting Act and the rules of the Medical Information Bureau.

This authorization and/or photocopy of it shall be valid for a period of twenty-four (24) months after the date it is signed. I understand I can revoke this authorization at any time by submitting a written request to the Company at its Home Office.

First Insured's Signature

Second Insured's Signature

Agent's Signature

Date

REQUIRED NOTICE TO APPLICANT

Details & Remarks: _____

Home Office Endorsements:

ASSIGNMENT

I/WE hereby assign to _____, assignee, the proceeds due to become due under the life insurance policy hereby applied for when issued to the extent of any indebtedness due by me/us to said assignee. I/WE agree that in the event of any default Assignee is authorized to cancel this insurance and credit any premium refund toward my indebtedness as his interest may appear. I also agree that this assignment is irrevocable until all indebtedness due Assignee by me/us has been paid in full and that the rights and interest of any beneficiary under said policy are subordinate to the rights and interest of the Assignee.

Signed at _____ this _____ day of _____ 20 _____.

First Insured

The foregoing assignment is filed at the Company's Home Office this

_____ day of _____, 20 _____.

Policy # _____

Wichita National Life Insurance Company

Who is to pay premium? ☐ Insured ☐ Assignee

AGENT'S CERTIFICATION: I certify that I have personally asked the applicant all of the above questions. I have accurately recorded the facts supplied by the applicant. Pre-notice of the Medical Information Bureau and Fair Credit Reporting Act was given to the applicant prior to completing this application.

Do you have reason to believe that replacement of any existing insurance or annuity may be involved?

☐ YES ☐ NO (if "Yes," explain in "Details and Remarks.")

CASH RECEIVED WITH APPLICATION: LIFE:\$ _____

Soliciting Agent

AGENT INSTRUCTIONS — REMEMBER, GOOD INSTRUCTIONS = FAST ISSUE.

Procedures For Completing This Life Application — When Applying For:

Complete all questions.

- A. The applicant's signature should be obtained on all life applications.
- B. Be sure that required forms are submitted when disclosure is required with life applications, and that all required forms are completed and submitted.
- C. Under "AGENT'S CERTIFICATION," be sure to sign your name on the application, and also submit with the application all forms required when a replacement is involved.

APP 1 Use this application for all risks UNDER \$100,000

WICHITA NATIONAL LIFE INSURANCE COMPANY

711 SW D Avenue • P. O. Box 1709 • Lawton, OK. 73502

AMOUNT APPLIED FOR _____
PREMIUM _____

APPLICATION FOR:

☐ Single Life — One Person Insured

☐ Mortgage Protection

☐ Joint Life — Two Persons Insured

☐ Whole Life

(Both must complete, date & sign the application)

☐ Annual Renewable Term

☐ Level Term Protection

☐ Automatic Premium Loan

☐ Rider _____

NAME OF FIRST
PROPOSED
INSURED _____

ADDRESS _____

CITY, STATE, ZIP _____

SOCIAL SECURITY NUMBER _____

PRIMARY
BENEFICIARY
& RELATIONSHIP _____

CONTINGENT
BENEFICIARY
& RELATIONSHIP _____

OWNER IF
NOT PROPOSED
INSURED _____

MODE OF PAYMENT				
ANNUAL	SEMI ANNUAL	QUARTERLY	MONTHLY	BANK DRAFT
OFFICE USE ONLY				
CWA <input type="checkbox"/> Y <input type="checkbox"/> N	POLICY #	AGENT #	PLAN #	TERM

NAME OF SECOND
PROPOSED
INSURED _____

ADDRESS _____

CITY, STATE, ZIP _____

SOCIAL SECURITY NUMBER _____

PRIMARY
BENEFICIARY
& RELATIONSHIP _____

CONTINGENT
BENEFICIARY
& RELATIONSHIP _____

OWNER IF
NOT PROPOSED
INSURED _____

INSURED	DATE OF BIRTH	AGE	STATE OF BIRTH	HEIGHT	WEIGHT	SEX	OCCUPATION	HOME PHONE	WORK PHONE
FIRST									
SECOND									

IF NOT ACTIVELY WORKING, PLEASE EXPLAIN

- Have you ever been told you have or have you been treated for any of the following disorders or diseases: cancer, epilepsy, heart attack, heart murmur, irregular heartbeat or any other heart defect, high blood pressure, diabetes, circulatory disease, nervous or mental disorder or disorder of the brain, nervous system, liver, kidney, lung or respiratory disease?
- Within the last 5 years have you consulted, been examined or treated by a physician or have you been under observation or treated at a clinic, hospital or sanitarium or have you ever been rated or declined for life insurance?
- Have you ever used or been treated for the use of illegal drugs or ever received treatment for or joined an organization for alcoholism or alcohol abuse?
- Do you know of any impairment, disease or disorder now existing in your health or mental condition for which you have not seen a physician?
- Have you ever been told you have or have you been treated for an immune deficiency disorder, AIDS the AIDS related complex (ARC) or tested positive for the AIDS virus?
- Have you used tobacco during the past twelve (12) months?
- Has any insurance been cancelled, or the renewal or reinstatement been refused?

FIRST INSURED	SECOND INSURED
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

COMPLETE IF ANY QUESTION ABOVE MARKED YES (ADDITIONAL SPACE ON REVERSE SIDE.)

QUESTIONS NUMBER	INSURED	DETAILS	FROM	DATES	TO	RESULTS INCLUDING TREATMENT IF ANY	NAME & ADDRESS OF DOCTOR ON DATE OF LAST VISIT

WARNING: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

I/we hereby declare that to the best of my/our knowledge and belief the above statements and answers to the above questions are complete and true. I/we agree that this application, any amendment thereto, and any added declaration thereto, shall become a part of the policy herein applied for. Application is hereby made for insurance on the life(s) of the proposed insured(s). It is understood that the Company shall incur no liability because of this application unless it is approved by the Company, and the first premium is paid while the health and other conditions affecting the insurability of the proposed insured(s) are as described in this application.

Authorization: "I/we hereby authorize any licensed doctor, or medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution, or person that has any records or knowledge of me (us) or my (our) health to give the Company, or its reinsurer(s) any such information. **NOTICE:** Information authorized for release may include information on physicals, drug, alcohol, communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, HIV/AIDS (Human Immune Deficiency Virus / Acquired Immune Deficiency Syndrome), or other conditions for which I may have been treated while a patient here. I/we acknowledge receipt of the notification form issued in compliance with the Fair Credit Reporting Act and the rules of the Medical Information Bureau.

This authorization and/or photocopy of it shall be valid for a period of twenty-four (24) months after the date it is signed. I understand I can revoke this authorization at any time by submitting a written request to the Company at its Home Office.

First Insured's Signature

Second Insured's Signature

Agent's Signature

Date

REQUIRED NOTICE TO APPLICANT

Details & Remarks: _____

Home Office Endorsements:

ASSIGNMENT

I/WE hereby assign to _____, assignee, the proceeds due to become due under the life insurance policy hereby applied for when issued to the extent of any indebtedness due by me/us to said assignee. I/WE agree that in the event of any default Assignee is authorized to cancel this insurance and credit any premium refund toward my indebtedness as his interest may appear. I also agree that this assignment is irrevocable until all indebtedness due Assignee by me/us has been paid in full and that the rights and interest of any beneficiary under said policy are subordinate to the rights and interest of the Assignee.

Signed at _____ this _____ day of _____ 20 _____.

First Insured

The foregoing assignment is filed at the Company's Home Office this

_____ day of _____, 20 _____.

Policy # _____

Wichita National Life Insurance Company

Who is to pay premium? ☐ Insured ☐ Assignee

AGENT'S CERTIFICATION: I certify that I have personally asked the applicant all of the above questions. I have accurately recorded the facts supplied by the applicant. Pre-notice of the Medical Information Bureau and Fair Credit Reporting Act was given to the applicant prior to completing this application.

Do you have reason to believe that replacement of any existing insurance or annuity may be involved?

☐ YES ☐ NO (if "Yes," explain in "Details and Remarks.")

CASH RECEIVED WITH APPLICATION: LIFE:\$ _____

Soliciting Agent

AGENT INSTRUCTIONS — REMEMBER, GOOD INSTRUCTIONS = FAST ISSUE.

Procedures For Completing This Life Application — When Applying For:

Complete all questions.

- The applicant's signature should be obtained on all life applications.
- Be sure that required forms are submitted when disclosure is required with life applications, and that all required forms are completed and submitted.
- Under "AGENT'S CERTIFICATION," be sure to sign your name on the application, and also submit with the application all forms required when a replacement is involved.

NAME AND ADDRESS OF BANK

**PLEASE SUBMIT A VOIDED
CHECK FOR PURPOSE OF
ENCODING THE BANK
ACCOUNT AND TRANSIT
NUMBER**

AUTHORIZATION TO HONOR CHECKS OR DRAFTS DRAWN BY WICHITA NATIONAL LIFE INSURANCE COMPANY, LAWTON, OKLAHOMA

As a convenience to me, I hereby request and authorize you to pay and charge my account checks or drafts drawn on my account by and payable to the order of the Wichita National Life Insurance Company, Lawton, Oklahoma, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or draft shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing and until you actually receive such notice I agree that you shall be fully protected in honoring any such check or draft. I further agree that if any such check or draft be dishonored whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

To Bank			POLICY NUMBERS
Address Of Bank			
	STREET, CITY, STATE	ZIP	
CHECKING ACCOUNT NUMBER		ACCOUNT TITLE IF APPLICABLE	
Bank NOS	TODAY'S DATE	YOUR BANK SIGNATURE	

AN INDEMNIFICATION AGREEMENT IS BELOW — ATTACH VOID CHECK

INDEMNIFICATION AGREEMENT

TO: Bank named above

In consideration of your participating in a plan which Wichita National Life Insurance Company (hereinafter know as Company) has put into effect by which amounts due on policies of insurance are collected by checks drawn by the Company on the accounts of persons who are responsible for these payments., the Company does hereby agree that:

- (1) It will indemnify and hold you harmless from any liability to any person having an account with you arising out of the payments by you of any check drawn by the Company on the account of such person, or arising out of dishonor by you, whether with or without cause or intentionally or inadvertently, of any such check drawn by the Company, whether or not such claim or liability asserted against you be based upon the forfeiture, or alleged forfeiture, of a policy of insurance the premium on which is sought or be collected by the Company by any check and
- (2) The Company will refund to you any amount erroneously paid by you on any check if claim for the amount of such erroneous payment is made by you within twelve months from the date of the check on which such erroneous payment was made.
- (3) It will defend at its own cost and expense any action which might be brought by any depositor or any other persons because of you actions arising by your participating in the plan of premium collection for the Company.

This indemnification extends to any liability of yours arising out of the dishonor of such a check not only to persons having an account with your bank, but also to any owner or beneficiary of any policy issued by Wichita National Life Insurance Company in respect of which such a check is drawn.

WICHITA NATIONAL LIFE INSURANCE COMPANY CONDITIONAL RECEIPT

P.O. BOX 1709, LAWTON, OKLAHOMA 73502

1

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY: DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

No coverage will become effective prior to policy delivery and acceptance unless all conditions of this receipt are met. No agent and no broker has the authority to alter the terms or conditions of this receipt or coverage applied for.

Received \$_____ from _____ on _____ 20____ in connection with an application for life insurance bearing the same number as this receipt, for _____ (Type of consideration for such premium).

IF

1. An amount equal to the first full premium for the mode selected is submitted; and
2. All the underwriting requirements, including any medical examinations required by the company rules, are completed within 60 days from the date of the application; and
3. The proposed insured(s) are, on the Effective date defined immediately below, a risk acceptable for standard insurance **exactly as applied for without modifications of plan, premium rate, or amount** under the company's rules and practices.

THEN: Insurance under the policy applied for shall be considered in force of the effective date. The Effective Date is defined as the latter of:

- A. The date of completion of all underwriting requirements; or
- B. The date of issue requested in the application, if any.

Any check or draft given as the full premium payment must be honored on presentation to constitute a premium payment.

In any event the amount of life insurance including accidental death benefits which may become effective prior to policy delivery shall be \$100,000, or the amount of insurance requested in the application if such amount is less.

IF ANY OF THE ABOVE CONDITIONS ARE NOT MET THE LIABILITY TO THE COMPANY IS LIMITED TO THE RETURN OF THE AMOUNT OF PAYMENT SUBMITTED.

I have read and understand the conditions and limitations contained in this receipt.

Signature of Applicant

Signature of Witness

NOTICE TO PROPOSED INSURED — MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. Wichita National Life Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for such benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. (Medical information will be disclosed only to your attending physician.) If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02110, telephone number (617) 426-3660.

Wichita National Life Insurance Company or its reinsurers, may also release information in its file to its reinsurers or to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim or benefits may be submitted.

NOTICE TO INSURED — FAIR CREDIT REPORTING ACT

As a part of our underwriting procedure, a routine investigative consumer report may be made during the next few days, whereby information is obtained through personal interview with third parties, such as family members, business associates, financial sources, friends, neighbors, or others with whom you are acquainted. This report typically concerns information on your character, general reputation, personal characteristics and mode of living.

Additional information as to the nature and scope of this report, if one is made, will be provided to you upon written request. Should you wish to contact us about questions you may have, please write to:

WICHITA NATIONAL LIFE INSURANCE COMPANY
P.O. Box 1709 / Lawton, Oklahoma 73502

APP 2 Use this application for all risks \$100,000 and OVER

WICHITA NATIONAL LIFE INSURANCE COMPANY

711 SW D Avenue • P. O. Box 1709 • Lawton, OK. 73502

AMOUNT APPLIED FOR _____

PREMIUM

APPLICATION FOR:

- | | |
|---|--|
| <input type="checkbox"/> Whole Life | <input type="checkbox"/> Mortgage Protection |
| <input type="checkbox"/> Annual Renewable Term | <input type="checkbox"/> Level Term Protection |
| <input type="checkbox"/> Automatic Premium Loan | <input type="checkbox"/> Rider _____ |

MODE OF PAYMENT				
ANNUAL	SEMI ANNUAL	QUARTERLY	MONTHLY	BANK DRAFT
OFFICE USE ONLY				
CWA <input type="checkbox"/> Y <input type="checkbox"/> N	POLICY #	AGENT #	PLAN #	TERM
NAME OF PROPOSED INSURED		SOCIAL SECURITY NO.	SEX	AGE
ADDRESS		HOME PHONE	BIRTH STATE	HEIGHT
CITY, STATE, ZIP		OCCUPATION		
EMPLOYER		YEARS EMPLOYED	BUSINESS PHONE	
ADDRESS		NAME AND ADDRESS OF POLICY OWNER IF NOT PROPOSED INSURED. (IF PAYER IS NOT OWNER, GIVE NAME AND ADDRESS IN "REMARKS")		
CITY, STATE, ZIP				
PRIMARY BENEFICIARY		RELATIONSHIP	CONTINGENT BENEFICIARY	
			RELATIONSHIP	

NON-SMOKER ELIGIBILITY

Have you used tobacco within the past 12 months? ☐ Y ☐ N

AVIATION, AVOCATION, FOREIGN TRAVEL, AND MILITARY.

During the past 3 years has any proposed insured participated in, or contemplated participation in:

- Flights as a pilot, student pilot, or crew member of an aircraft? ☐ Y ☐ N
- Skin diving, scuba diving, skydiving, parachuting, hang gliding, auto racing, motorcycle racing, speedboat racing, mountain climbing or rodeos? ☐ Y ☐ N

If "YES" complete aviation or avocation questionnaire.

Is any change in residence, occupation or travel outside the U.S.A. or Canada contemplated by any proposed insured?

If "YES" explain in the "DETAILS AND REMARKS" section on reverse side.

Military-is any proposed insured a member of the Armed Forces or any reserve component? ☐ Y ☐ N

If "YES" indicate **Branch** _____ **Rank** _____

HAS ANY PROPOSED INSURED EVER BEEN TREATED FOR OR HAD ANY KNOWN INDICATION OF: CIRCLE CONDITION.

- Heart or circulatory disease, high blood pressure, varicose veins, phlebitis? ☐ Y ☐ N
- Disorder of lungs or respiratory systems, stomach, intestines, or liver? ☐ Y ☐ N
- Disorder of kidneys, or urinary tract, reproductive organs, prostate, or breast? ☐ Y ☐ N
- Arthritis, cancer or tumor, disease of , or injury to neck, back or spine, muscles, joints, sciatica, or bodily deformity? ☐ Y ☐ N
- Disease or impairment of the eyes, ears, or nervous or mental disorder? ☐ Y ☐ N
- Alcoholism or drug usage, not physician prescribed? ☐ Y ☐ N
- Diabetes, thyroid or other endocrine disease? ☐ Y ☐ N
- Any existing injury, deformity, disease condition or disorder not listed above within the last 5 years? ☐ Y ☐ N
- Have you ever been told you have or have you been treated for an immune deficiency disorder, AIDS, the AIDS related complex (ARC) or tested positive for the AIDS virus? ☐ Y ☐ N

IF ANY OF THE ABOVE QUESTIONS ARE ANSWERED "YES" EXPLAIN BELOW:
(ADDITIONAL SPACE ON REVERSE SIDE)

REASON FOR TREATMENT or CONSULTATION	DATE MO/YR	NAME & ADDRESS of DOCTOR and/or HOSPITAL

NAME AND ADDRESS OF PERSONAL PHYSICIAN

DATE AND REASON LAST SEEN

PLAN APPLIED FOR

PLAN NAME	AMT. OF INS.	RATE	PREMIUM
RIDERS		X	=
		X	=
		X	=

FAMILY HISTORY: Has any family member had tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide? ☐ Yes ☐ No
(Circle Condition).

	Age if Living	Cause of Death	Age at Death
FATHER			
MOTHER			

Is insurance applied for to replace or change life insurance or annuity in this or any other company? ☐ Y ☐ N

Has any proposed insured ever applied for any life, accident, or health insurance which has not been granted as applied for in kind, amount or rate, or has any insurance been cancelled or the renewal or reinstatement thereof been refused? ☐ Y ☐ N

Is there any application for life, accident, or health insurance on any proposed insured now pending in any other company? ☐ Y ☐ N

If "YES" give full particulars in the "Details and Remarks" section.

TOTAL LIFE INSURANCE IN FORCE ON PROPOSED INSURED(S)

LIFE AMOUNT	\$	TOTAL ADB	\$
ISSUE YEAR	COMPANY	PLAN	AMOUNTS OF INSURANCE LIFE ADB

WARNING: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

AUTHORIZATION AND ACKNOWLEDGEMENT STATEMENT FOR PROPOSED INSURANCE FOR THE APPLICANT

I hereby declare that to the best of my knowledge and belief the above statements and answers to the above questions are complete and true. I agree that this application, any amendment thereto, and any added declaration thereto, shall become a part of the policy herein applied for. Application is hereby made for insurance on the life of the proposed insured. It is understood that the Company shall incur no liability because of this application unless it is approved by the Company, and the first premium is paid while the health and other conditions affecting the insurability of the proposed insured are as described in this application.

Authorization: "I hereby authorize any licensed doctor, or medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution, or person that has any records or knowledge of me or my health to give the Company, or its reinsurer(s) any such information. **NOTICE:** Information authorized for release may include information on physicals, drug, alcohol, communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, HIV/AIDS (Human Immune Deficiency Virus / Acquired Immune Deficiency Syndrome), or other conditions for which I may have been treated while a patient there. I acknowledge receipt of the notification form issued in compliance with the Fair Credit Reporting Act and the rules of the Medical Information Bureau.

This authorization and/or photocopy of it shall be valid for a period of twenty-four (24) months after the date it is signed. I understand I can revoke this authorization at any time by submitting a written request to the Company at its Home Office.

PROPOSED INSURED'S SIGNATURE	DATE
AGENTS SIGNATURE	DATE

REQUIRED NOTICE TO APPLICANT

Details & Remarks: _____

Home Office Endorsements:

ASSIGNMENT

I/WE hereby assign to _____, assignee, the proceeds due to become due under the life insurance policy hereby applied for when issued to the extent of any indebtedness due by me/us to said assignee. I/WE agree that in the event of any default Assignee is authorized to cancel this insurance and credit any premium refund toward my indebtedness as his interest may appear. I also agree that this assignment is irrevocable until all indebtedness due Assignee by me/us has been paid in full and that the rights and interest of any beneficiary under said policy are subordinate to the rights and interest of the Assignee.

Signed at _____ this _____ day of _____ 20 _____.

First Insured

The foregoing assignment is filed at the Company's Home Office this

_____ day of _____, 20 _____.

Policy # _____
Wichita National Life Insurance Company

Who is to pay premium? ☐ Insured ☐ Assignee

AGENT'S CERTIFICATION: I certify that I have personally asked the applicant all of the above questions. I have accurately recorded the facts supplied by the applicant. Pre-notice of the Medical Information Bureau and Fair Credit Reporting Act was given to the applicant prior to completing this application.

Do you have reason to believe that replacement of any existing insurance or annuity may be involved?

☐ YES ☐ NO (if "Yes," explain in "Details and Remarks.")

_____ CASH RECEIVED WITH APPLICATION: LIFE:\$ _____

Soliciting Agent

AGENT INSTRUCTIONS — REMEMBER, GOOD INSTRUCTIONS = FAST ISSUE.

Procedures For Completing This Life Application — When Applying For:

Complete all questions.

- A. The applicant's signature should be obtained on all life applications.
- B. Be sure that required forms are submitted when disclosure is required with life applications, and that all required forms are completed and submitted.
- C. Under "AGENT'S CERTIFICATION," be sure to sign your name on the application, and also submit with the application all forms required when a replacement is involved.

APP 2 Use this application for all risks \$100,000 and OVER

WICHITA NATIONAL LIFE INSURANCE COMPANY

711 SW D Avenue • P. O. Box 1709 • Lawton, OK. 73502

AMOUNT APPLIED FOR _____

PREMIUM

APPLICATION FOR:

- | | |
|---|--|
| <input type="checkbox"/> Whole Life | <input type="checkbox"/> Mortgage Protection |
| <input type="checkbox"/> Annual Renewable Term | <input type="checkbox"/> Level Term Protection |
| <input type="checkbox"/> Automatic Premium Loan | <input type="checkbox"/> Rider _____ |

MODE OF PAYMENT				
ANNUAL	SEMI ANNUAL	QUARTERLY	MONTHLY	BANK DRAFT
OFFICE USE ONLY				
CWA <input type="checkbox"/> Y <input type="checkbox"/> N	POLICY #	AGENT #	PLAN #	TERM
NAME OF PROPOSED INSURED		SOCIAL SECURITY NO.	SEX	AGE
ADDRESS		HOME PHONE	BIRTH STATE	HEIGHT
CITY, STATE, ZIP		OCCUPATION		
EMPLOYER		YEARS EMPLOYED	BUSINESS PHONE	
ADDRESS		NAME AND ADDRESS OF POLICY OWNER IF NOT PROPOSED INSURED. (IF PAYER IS NOT OWNER, GIVE NAME AND ADDRESS IN "REMARKS")		
CITY, STATE, ZIP				
PRIMARY BENEFICIARY	RELATIONSHIP	CONTINGENT BENEFICIARY	RELATIONSHIP	

NON-SMOKER ELIGIBILITY

Have you used tobacco within the past 12 months? ☐ Y ☐ N

AVIATION, AVOCATION, FOREIGN TRAVEL, AND MILITARY.

During the past 3 years has any proposed insured participated in, or contemplated participation in:

- Flights as a pilot, student pilot, or crew member of an aircraft? ☐ Y ☐ N
- Skin diving, scuba diving, skydiving, parachuting, hang gliding, auto racing, motorcycle racing, speedboat racing, mountain climbing or rodeos? ☐ Y ☐ N

If "YES" complete aviation or avocation questionnaire.

Is any change in residence, occupation or travel outside the U.S.A. or Canada contemplated by any proposed insured?

If "YES" explain in the "DETAILS AND REMARKS" section on reverse side.

Military-is any proposed insured a member of the Armed Forces or any reserve component? ☐ Y ☐ N

If "YES" indicate **Branch** _____ **Rank** _____

HAS ANY PROPOSED INSURED EVER BEEN TREATED FOR OR HAD ANY KNOWN INDICATION OF: CIRCLE CONDITION.

- Heart or circulatory disease, high blood pressure, varicose veins, phlebitis? ☐ Y ☐ N
- Disorder of lungs or respiratory systems, stomach, intestines, or liver? ☐ Y ☐ N
- Disorder of kidneys, or urinary tract, reproductive organs, prostate, or breast? ☐ Y ☐ N
- Arthritis, cancer or tumor, disease of , or injury to neck, back or spine, muscles, joints, sciatica, or bodily deformity? ☐ Y ☐ N
- Disease or impairment of the eyes, ears, or nervous or mental disorder? ☐ Y ☐ N
- Alcoholism or drug usage, not physician prescribed? ☐ Y ☐ N
- Diabetes, thyroid or other endocrine disease? ☐ Y ☐ N
- Any existing injury, deformity, disease condition or disorder not listed above within the last 5 years? ☐ Y ☐ N
- Have you ever been told you have or have you been treated for an immune deficiency disorder, AIDS, the AIDS related complex (ARC) or tested positive for the AIDS virus? ☐ Y ☐ N

IF ANY OF THE ABOVE QUESTIONS ARE ANSWERED "YES" EXPLAIN BELOW:
(ADDITIONAL SPACE ON REVERSE SIDE)

REASON FOR TREATMENT or CONSULTATION	DATE MO/YR	NAME & ADDRESS of DOCTOR and/or HOSPITAL

NAME AND ADDRESS OF PERSONAL PHYSICIAN

DATE AND REASON LAST SEEN

PLAN APPLIED FOR

PLAN NAME	AMT. OF INS.	RATE	PREMIUM
RIDERS		X	=
		X	=
		X	=

FAMILY HISTORY: Has any family member had tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide? ☐ Yes ☐ No
(Circle Condition).

	Age if Living	Cause of Death	Age at Death
FATHER			
MOTHER			

Is insurance applied for to replace or change life insurance or annuity in this or any other company? ☐ Y ☐ N

Has any proposed insured ever applied for any life, accident, or health insurance which has not been granted as applied for in kind, amount or rate, or has any insurance been cancelled or the renewal or reinstatement thereof been refused? ☐ Y ☐ N

Is there any application for life, accident, or health insurance on any proposed insured now pending in any other company? ☐ Y ☐ N

If "YES" give full particulars in the "Details and Remarks" section.

TOTAL LIFE INSURANCE IN FORCE ON PROPOSED INSURED(S)

LIFE AMOUNT	\$	TOTAL ADB	\$
ISSUE YEAR	COMPANY	PLAN	AMOUNTS OF INSURANCE LIFE ADB

WARNING: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

AUTHORIZATION AND ACKNOWLEDGEMENT STATEMENT FOR PROPOSED INSURANCE FOR THE APPLICANT

I hereby declare that to the best of my knowledge and belief the above statements and answers to the above questions are complete and true. I agree that this application, any amendment thereto, and any added declaration thereto, shall become a part of the policy herein applied for. Application is hereby made for insurance on the life of the proposed insured. It is understood that the Company shall incur no liability because of this application unless it is approved by the Company, and the first premium is paid while the health and other conditions affecting the insurability of the proposed insured are as described in this application.

Authorization: "I hereby authorize any licensed doctor, or medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution, or person that has any records or knowledge of me or my health to give the Company, or its reinsurer(s) any such information. **NOTICE:** Information authorized for release may include information on physicals, drug, alcohol, communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, HIV/AIDS (Human Immune Deficiency Virus / Acquired Immune Deficiency Syndrome), or other conditions for which I may have been treated while a patient there. I acknowledge receipt of the notification form issued in compliance with the Fair Credit Reporting Act and the rules of the Medical Information Bureau.

This authorization and/or photocopy of it shall be valid for a period of twenty-four (24) months after the date it is signed. I understand I can revoke this authorization at any time by submitting a written request to the Company at its Home Office.

PROPOSED INSURED'S SIGNATURE	DATE
AGENTS SIGNATURE	DATE

REQUIRED NOTICE TO APPLICANT

Details & Remarks: _____

Home Office Endorsements:

ASSIGNMENT

I/WE hereby assign to _____, assignee, the proceeds due to become due under the life insurance policy hereby applied for when issued to the extent of any indebtedness due by me/us to said assignee. I/WE agree that in the event of any default Assignee is authorized to cancel this insurance and credit any premium refund toward my indebtedness as his interest may appear. I also agree that this assignment is irrevocable until all indebtedness due Assignee by me/us has been paid in full and that the rights and interest of any beneficiary under said policy are subordinate to the rights and interest of the Assignee.

Signed at _____ this _____ day of _____ 20 _____.

First Insured

The foregoing assignment is filed at the Company's Home Office this

_____ day of _____, 20 _____.

Policy # _____

Wichita National Life Insurance Company

Who is to pay premium? ☐ Insured ☐ Assignee

AGENT'S CERTIFICATION: I certify that I have personally asked the applicant all of the above questions. I have accurately recorded the facts supplied by the applicant. Pre-notice of the Medical Information Bureau and Fair Credit Reporting Act was given to the applicant prior to completing this application.

Do you have reason to believe that replacement of any existing insurance or annuity may be involved?

☐ YES ☐ NO (if "Yes," explain in "Details and Remarks.")

CASH RECEIVED WITH APPLICATION: LIFE:\$ _____

Soliciting Agent

AGENT INSTRUCTIONS — REMEMBER, GOOD INSTRUCTIONS = FAST ISSUE.

Procedures For Completing This Life Application — When Applying For:

Complete all questions.

- A. The applicant's signature should be obtained on all life applications.
- B. Be sure that required forms are submitted when disclosure is required with life applications, and that all required forms are completed and submitted.
- C. Under "AGENT'S CERTIFICATION," be sure to sign your name on the application, and also submit with the application all forms required when a replacement is involved.

WICHITA NATIONAL LIFE INSURANCE COMPANY

711 SW D Avenue • P. O. Box 1709 • Lawton, OK. 73502

AMOUNT APPLIED FOR _____

PREMIUM

APPLICATION FOR:

- ☐ Whole Life ☐ Mortgage Protection
- ☐ Annual Renewable Term ☐ Level Term Protection
- ☐ Automatic Premium Loan ☐ Rider _____

NAME OF PROPOSED INSURED		SOCIAL SECURITY NO.		SEX	AGE	DATE OF BIRTH	
ADDRESS		HOME PHONE		BIRTH STATE		HEIGHT	WEIGHT
CITY, STATE, ZIP		OCCUPATION					
EMPLOYER		YEARS EMPLOYED				BUSINESS PHONE	
ADDRESS		NAME AND ADDRESS OF POLICY OWNER IF NOT PROPOSED INSURED. (IF PAYER IS NOT OWNER, GIVE NAME AND ADDRESS IN "REMARKS")					
CITY, STATE, ZIP							
PRIMARY BENEFICIARY		RELATIONSHIP		CONTINGENT BENEFICIARY		RELATIONSHIP	

NON-SMOKER ELIGIBILITY

Have you used tobacco within the past 12 months?

☐ Y ☐ N

AVIATION, AVOCATION, FOREIGN TRAVEL, AND MILITARY.

During the past 3 years has any proposed insured participated in, or contemplated participation in:

1. Flights as a pilot, student pilot, or crew member of an aircraft? ☐ Y ☐ N
2. Skin diving, scuba diving, skydiving, parachuting, hang gliding, auto racing, motorcycle racing, speedboat racing, mountain climbing or rodeos? ☐ Y ☐ N

If "YES" complete aviation or avocation questionnaire.

Is any change in residence, occupation or travel outside the U.S.A. or Canada contemplated by any proposed insured?

If "YES" explain in the "DETAILS AND REMARKS" section on reverse side.

☐ Y ☐ N

Military-is any proposed insured a member of the Armed Forces or any reserve component?

☐ Y ☐ N

If "YES" indicate Branch _____ Rank _____

HAS ANY PROPOSED INSURED EVER BEEN TREATED FOR OR HAD ANY KNOWN INDICATION OF: CIRCLE CONDITION.

1. Heart or circulatory disease, high blood pressure, varicose veins, phlebitis? ☐ Y ☐ N
2. Disorder of lungs or respiratory systems, stomach, intestines, or liver? ☐ Y ☐ N
3. Disorder of kidneys, or urinary tract, reproductive organs, prostate, or breast? ☐ Y ☐ N
4. Arthritis, cancer or tumor, disease of , or injury to neck, back or spine, muscles, joints, sciatica, or bodily deformity? ☐ Y ☐ N
5. Disease or impairment of the eyes, ears, or nervous or mental disorder? ☐ Y ☐ N
6. Alcoholism or drug usage, not physician prescribed? ☐ Y ☐ N
7. Diabetes, thyroid or other endocrine disease? ☐ Y ☐ N
8. Any existing injury, deformity, disease condition or disorder not listed above within the last 5 years? ☐ Y ☐ N
9. Have you ever been told you have or have you been treated for an immune deficiency disorder, AIDS, the AIDS related complex (ARC) or tested positive for the AIDS virus? ☐ Y ☐ N

☐ Y ☐ NIF ANY OF THE ABOVE QUESTIONS ARE ANSWERED "YES" EXPLAIN BELOW:
(ADDITIONAL SPACE ON REVERSE SIDE)

REASON FOR TREATMENT or CONSULTATION	DATE MO/YR	NAME & ADDRESS of DOCTOR and/or HOSPITAL

NAME AND ADDRESS OF PERSONAL PHYSICIAN

DATE AND REASON LAST SEEN

PLAN APPLIED FOR

PLAN NAME	AMT. OF INS.	RATE	PREMIUM
RIDERS		X	=
		X	=
		X	=

FAMILY HISTORY: Has any family member had tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide? ☐ Yes ☐ No (Circle Condition).

	Age if Living	Cause of Death	Age at Death
FATHER			
MOTHER			

Is insurance applied for to replace or change life insurance or annuity in this or any other company?

☐ Y ☐ N

Has any proposed insured ever applied for any life, accident, or health insurance which has not been granted as applied for in kind, amount or rate, or has any insurance been cancelled or the renewal or reinstatement thereof been refused?

☐ Y ☐ N

Is there any application for life, accident, or health insurance on any proposed insured now pending in any other company?

☐ Y ☐ N

If "YES" give full particulars in the "Details and Remarks" section.

TOTAL LIFE INSURANCE IN FORCE ON PROPOSED INSURED(S)

LIFE AMOUNT	\$	TOTAL ADB	\$
ISSUE YEAR	COMPANY	PLAN	AMOUNTS OF INSURANCE LIFE ADB

WARNING: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

AUTHORIZATION AND ACKNOWLEDGEMENT STATEMENT FOR PROPOSED INSURANCE FOR THE APPLICANT

I hereby declare that to the best of my knowledge and belief the above statements and answers to the above questions are complete and true. I agree that this application, any amendment thereto, and any added declaration thereto, shall become a part of the policy herein applied for. Application is hereby made for insurance on the life of the proposed insured. It is understood that the Company shall incur no liability because of this application unless it is approved by the Company, and the first premium is paid while the health and other conditions affecting the insurability of the proposed insured are as described in this application.

Authorization: "I hereby authorize any licensed doctor, or medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution, or person that has any records or knowledge of me or my health to give the Company, or its reinsurer(s) any such information. NOTICE: Information authorized for release may include information on physicals, drug, alcohol, communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, HIV/AIDS (Human Immune Deficiency Virus / Acquired Immune Deficiency Syndrome), or other conditions for which I may have been treated while a patient there. I acknowledge receipt of the notification form issued in compliance with the Fair Credit Reporting Act and the rules of the Medical Information Bureau.

This authorization and/or photocopy of it shall be valid for a period of twenty-four (24) months after the date it is signed. I understand I can revoke this authorization at any time by submitting a written request to the Company at its Home Office.

PROPOSED INSURED'S SIGNATURE

DATE

AGENTS SIGNATURE

DATE

REQUIRED NOTICE TO APPLICANT

Details & Remarks: _____

Home Office Endorsements:

ASSIGNMENT

I/WE hereby assign to _____, assignee, the proceeds due to become due under the life insurance policy hereby applied for when issued to the extent of any indebtedness due by me/us to said assignee. I/WE agree that in the event of any default Assignee is authorized to cancel this insurance and credit any premium refund toward my indebtedness as his interest may appear. I also agree that this assignment is irrevocable until all indebtedness due Assignee by me/us has been paid in full and that the rights and interest of any beneficiary under said policy are subordinate to the rights and interest of the Assignee.

Signed at _____ this _____ day of _____ 20 _____.

First Insured

The foregoing assignment is filed at the Company's Home Office this

_____ day of _____, 20 _____.

Policy # _____

Wichita National Life Insurance Company

Who is to pay premium? ☐ Insured ☐ Assignee

AGENT'S CERTIFICATION: I certify that I have personally asked the applicant all of the above questions. I have accurately recorded the facts supplied by the applicant. Pre-notice of the Medical Information Bureau and Fair Credit Reporting Act was given to the applicant prior to completing this application.

Do you have reason to believe that replacement of any existing insurance or annuity may be involved?

☐ YES ☐ NO (if "Yes," explain in "Details and Remarks.")

CASH RECEIVED WITH APPLICATION: LIFE:\$ _____

Soliciting Agent

AGENT INSTRUCTIONS — REMEMBER, GOOD INSTRUCTIONS = FAST ISSUE.

Procedures For Completing This Life Application — When Applying For:

Complete all questions.

- A. The applicant's signature should be obtained on all life applications.
- B. Be sure that required forms are submitted when disclosure is required with life applications, and that all required forms are completed and submitted.
- C. Under "AGENT'S CERTIFICATION," be sure to sign your name on the application, and also submit with the application all forms required when a replacement is involved.

NAME AND ADDRESS OF BANK

**PLEASE SUBMIT A VOIDED
CHECK FOR PURPOSE OF
ENCODING THE BANK
ACCOUNT AND TRANSIT
NUMBER**

AUTHORIZATION TO HONOR CHECKS OR DRAFTS DRAWN BY WICHITA NATIONAL LIFE INSURANCE COMPANY, LAWTON, OKLAHOMA

As a convenience to me, I hereby request and authorize you to pay and charge my account checks or drafts drawn on my account by and payable to the order of the Wichita National Life Insurance Company, Lawton, Oklahoma, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or draft shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing and until you actually receive such notice I agree that you shall be fully protected in honoring any such check or draft. I further agree that if any such check or draft be dishonored whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

To Bank			POLICY NUMBERS
Address Of Bank			
	STREET, CITY, STATE	ZIP	
CHECKING ACCOUNT NUMBER		ACCOUNT TITLE IF APPLICABLE	
Bank NOS	TODAY'S DATE	YOUR BANK SIGNATURE	

AN INDEMNIFICATION AGREEMENT IS BELOW — ATTACH VOID CHECK

INDEMNIFICATION AGREEMENT

TO: Bank named above

In consideration of your participating in a plan which Wichita National Life Insurance Company (hereinafter know as Company) has put into effect by which amounts due on policies of insurance are collected by checks drawn by the Company on the accounts of persons who are responsible for these payments., the Company does hereby agree that:

- (1) It will indemnify and hold you harmless from any liability to any person having an account with you arising out of the payments by you of any check drawn by the Company on the account of such person, or arising out of dishonor by you, whether with or without cause or intentionally or inadvertently, or any such check drawn by the Company, whether or not such claim or liability asserted against you be based upon the forfeiture, or alleged forfeiture, of a policy of insurance the premium on which is sought or be collected by the Company by any check and
- (2) The Company will refund to you any amount erroneously paid by you on any check if claim for the amount of such erroneous payment is made by you within twelve months from the date of the check on which such erroneous payment was made.
- (3) It will defend at its own cost and expense any action which might be brought by any depositor or any other persons because of your actions arising by your participating in the plan of premium collection for the Company.

This indemnification extends to any liability of yours arising out of the dishonor of such a check not only to persons having an account with your bank, but also to any owner or beneficiary of any policy issued by Wichita National Life Insurance Company in respect of which such a check is drawn.

WICHITA NATIONAL LIFE INSURANCE COMPANY CONDITIONAL RECEIPT

P.O. BOX 1709, LAWTON, OKLAHOMA 73502

2

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY: DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

No coverage will become effective prior to policy delivery and acceptance unless all conditions of this receipt are met. No agent and no broker has the authority to alter the terms or conditions of this receipt or coverage applied for.

Received \$ _____ from _____ on _____ 20____ in connection with an application for life insurance bearing the same number as this receipt, for _____ (Type of consideration for such premium).

IF

1. An amount equal to the first full premium for the mode selected is submitted; and
2. All the underwriting requirements, including any medical examinations required by the company rules, are completed within 60 days from the date of the application; and
3. The proposed insured(s) are, on the Effective date defined immediately below, a risk acceptable for standard insurance **exactly as applied for without modifications of plan, premium rate, or amount** under the company's rules and practices.

THEN: Insurance under the policy applied for shall be considered in force of the effective date. The Effective Date is defined as the latter of:

- A. The date of completion of all underwriting requirements; or
- B. The date of issue requested in the application, if any.

Any check or draft given as the full premium payment must be honored on presentation to constitute a premium payment.

In any event the amount of life insurance including accidental death benefits which may become effective prior to policy delivery shall be \$100,000, or the amount of insurance requested in the application if such amount is less.

IF ANY OF THE ABOVE CONDITIONS ARE NOT MET THE LIABILITY TO THE COMPANY IS LIMITED TO THE RETURN OF THE AMOUNT OF PAYMENT SUBMITTED.

I have read and understand the conditions and limitations contained in this receipt.

Signature of Applicant

Signature of Witness

NOTICE TO PROPOSED INSURED — MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. Wichita National Life Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for such benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. (Medical information will be disclosed only to your attending physician.) If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02110, telephone number (617) 426-3660.

Wichita National Life Insurance Company or its reinsurers, may also release information in its file to its reinsurers or to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim or benefits may be submitted.

NOTICE TO INSURED — FAIR CREDIT REPORTING ACT

As a part of our underwriting procedure, a routine investigative consumer report may be made during the next few days, whereby information is obtained through personal interview with third parties, such as family members, business associates, financial sources, friends, neighbors, or others with whom you are acquainted. This report typically concerns information on your character, general reputation, personal characteristics and mode of living.

Additional information as to the nature and scope of this report, if one is made, will be provided to you upon written request. Should you wish to contact us about questions you may have, please write to:

WICHITA NATIONAL LIFE INSURANCE COMPANY
P.O. Box 1709 / Lawton, Oklahoma 73502



INSURANCE COMPANY

November 25, 2008

TO WHOM IT MAY CONCERN:

This letter is to authorize Chris McCaul, of Rudd and Wisdom, Inc., 9500 Arboretum Blvd., Suite 200, Austin, Texas, to complete insurance product filings with state insurance departments on behalf of Wichita National Life Insurance Co.

Sincerely,

Ronnie Denham
Secretary

Rudd and Wisdom, Inc.

CONSULTING ACTUARIES

Mitchell L. Bilbe, F.S.A.
Evan L. Dial, F.S.A.
Philip S. Dial, F.S.A.
Charles V. Faerber, F.S.A., A.C.A.S.
Mark R. Fenlaw, F.S.A.
Carl L. Frammolino, F.S.A.
Kenneth J. Herbold, A.S.A.
Christopher S. Johnson, F.S.A.
Robert M. May, F.S.A.

9500 Arboretum Blvd., Suite 200
Austin, Texas 78759
Post Office Box 204209
Austin, Texas 78720-4209
Phone: (512) 346-1590
Fax: (512) 345-7437
E-mail: rw@ruddwisdom.com

J. Christopher McCaul, F.S.A.
Edward A. Mire, F.S.A.
Rebecca B. Morris, A.S.A.
Michael J. Muth, F.S.A.
Khiem Ngo, A.S.A.
Ronald W. Tobleman, F.S.A.
David G. Wilkes, F.S.A.
Valerie M. Zinzer, F.S.A.

December 9, 2008

Arkansas Insurance Department

Re: RDWS-125918448
Wichita National Life Insurance Co.
Form No. LWL (01/09)

With reference to the attached form, per A.C.A. 23-79-138, we will provide each policyowner with the servicing agent's name, address and phone number. The home office information is listed on the policy form.

I certify that this filing meets the provisions of Regulation 19s10B as well as all applicable requirements of the Department.

12/15/2008
Date


Chris McCaul

<i>SERFF Tracking Number:</i>	<i>RDWS-125918448</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Wichita National Life Insurance Co.</i>	<i>State Tracking Number:</i>	<i>40991</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>L071 Individual Life - Whole</i>	<i>Sub-TOI:</i>	<i>L071.101 Fixed/Indeterminate Premium - Single Life</i>
<i>Product Name:</i>	<i>Whole Life</i>		
<i>Project Name/Number:</i>	<i>Wichita National Whole Life-LWL (01/09)/</i>		

Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	Whole Life Form	11/24/2008	LWL(01-09).pdf
No original date	Supporting Document	Application	11/24/2008	

WICHITA NATIONAL LIFE INSURANCE COMPANY

Wichita National Building • 711 S.W. "D" Avenue • Lawton, Oklahoma 73501 • 580-353-5776

A Legal Reserve Capital Stock Company
(Hereafter called: we, our or us).

We Agree

- To pay the insurance benefits of this policy to the beneficiary upon receiving due proof of the insured's death, and
- To provide you with the other rights and benefits of this policy.

These agreements are subject to the provision of this policy.

10 Day Free Look

If for any reason you are not satisfied with your policy, you may cancel it by returning the policy to us or to your agent within 10 days after you receive it. If you do, we will refund the premium that was paid.

Signed for us at our home office

SECRETARY

PRESIDENT

Level Amount Whole Life Insurance
Level Premiums Payable to Specified Age or Until Prior Death of Insured
Face Amount Payable at Death
Non-Participating

DEFINITIONS

When we use the following words, this is what we mean:

THE INSURED

The person whose life is insured under this policy as shown on page 3.

YOU, YOUR

The owner of this policy is as shown in the application, unless subsequently changed as provided for in this policy. The owner is the insured unless otherwise stated.

BENEFICIARY

The person to receive the proceeds in the event of the insured's death.

POLICY DATE

The date coverage under this policy becomes effective and the date from which policy anniversaries, policy years, policy months and premium due dates are determined.

POLICY ANNIVERSARY

The same day and month as your policy date for each succeeding year your policy remains in force.

WRITTEN REQUEST

A request in writing signed by you on a form agreeable to us. We also may require that your policy be sent in with your written request.

PROCEEDS

The amount we are obligated to pay under the terms of this policy when your policy is surrendered, matures, or when the insured dies.

IN FORCE

The period of time the insured's life remains insured under the terms of this policy.

LAPSE OR LAPSED

A premium is in default, and the insured's life is no longer insured under the terms of this policy except as may be provided for in the Guaranteed Value Options section (see page 6).

REINSTATE

To restore coverage after the policy has lapsed.

TERMINATE

The insured's life is no longer insured under any of the terms of this policy.

INDEBTEDNESS

All policy and premium loans, accrued interest and any due and unpaid premium.

AGE

The insured's age at the insured's last birthday, unless we state otherwise.

POLICY SPECIFICATIONS PAGE

TYPE OF COVERAGE	AMOUNT	PREMIUM PAYABLE	ANNUAL PREMIUM
[Whole Life]	[\$25,000]	[for Life]	[\$354.00]

Total Annual Premium on Policy Date

The Premiums for a benefit are payable for the lifetime of the insured, the first due on the Policy Date.

SCHEDULE OF TOTAL PREMIUMS

Annual	Semi-Annual	Quarterly	Monthly
[\$354.00]	[\$184.08]	[\$92.04]	[\$92.04]

PREMIUM CLASS:

POLICY LOAN INTEREST RATE: 7.4% per annum, or less. We may change the interest rate, but never will it exceed 7.4%. We will give written notice of the change to you or any assignee of record at least 30 days before the change becomes effective. Interest is payable at the end of the policy year.

REINSTATEMENT INTEREST RATE: 6% per annum

POLICY NUMBER: [12345W]

FACE AMOUNT: [\$25,000]

AGE / SEX: [35 Male]

INSURED: [John Doe]

POLICY DATE: [January 1, 2009]

POLICY SPECIFICATIONS

The values in the following table assume that all premiums are paid when due and no policy loans are taken. Policy values not illustrated will be furnished upon request.

End of Policy Year	Amount of Insurance	Cash Value	Reduced Paid Up	Extended Term Insurance	
				Years	Days
1	[25,000]	[0]	[0]	[0]	[0]
2	[25,000]	[0]	[0]	[0]	[0]
3	[25,000]	[200]	[875]	[5]	[64]
4	[25,000]	[450]	[1,875]	[9]	[187]
5	[25,000]	[725]	[2,925]	[13]	[64]
6	[25,000]	[1,000]	[3,875]	[15]	[234]
7	[25,000]	[1,300]	[4,875]	[17]	[229]
8	[25,000]	[1,600]	[5,800]	[19]	[33]
9	[25,000]	[1,900]	[6,650]	[20]	[38]
10	[25,000]	[2,225]	[7,525]	[20]	[356]
11	[25,000]	[2,550]	[8,350]	[21]	[227]
12	[25,000]	[2,875]	[9,100]	[22]	[39]
13	[25,000]	[3,200]	[9,800]	[22]	[161]
14	[25,000]	[3,550]	[10,525]	[22]	[272]
15	[25,000]	[3,925]	[11,275]	[23]	[0]
16	[25,000]	[4,300]	[11,950]	[23]	[45]
17	[25,000]	[4,675]	[12,600]	[23]	[53]
18	[25,000]	[5,050]	[13,175]	[23]	[31]
19	[25,000]	[5,450]	[13,775]	[23]	[11]
20	[25,000]	[5,850]	[14,350]	[22]	[329]
Age 60	[25,000]	[7,950]	[16,825]	[21]	[246]
Age 65	[25,000]	[10,175]	[18,800]	[19]	[303]
Age 70	[25,000]	[12,450]	[20,375]	[17]	[229]

The cash values, reduced paid up extended term values are based upon the [2001 Commissioners Standard Ordinary] mortality table, age last birthday and an annual interest rate of [4.0%]. The reserves are calculated based on the [2001 Commissioners Standard Ordinary] mortality table, age last birthday and an annual interest rate of [4.0%]. Premiums are payable for life.

GENERAL INFORMATION

THE CONTRACT

Your policy is issued in consideration of the application and the payment of premiums as provided for in this policy.

Your policy and the copy of the application attached to it contains the entire contract between you and us. Any statements made in the application either by you or by the insured will, in the absence of fraud, be considered representations and not warranties. Also, any written statements made either by you or by the insured will not be used to void your policy nor defend against a claim under your policy unless the statement is contained in the application.

No change or waiver of any of the provisions of this policy will be valid unless made in writing by us and signed by our president, a vice president, our secretary or an officer of the company. No agent or other person has the authority to change or waive any provision of your policy.

Any extra benefit rider attached to this policy will become a part of this policy and will be subject to all the terms and conditions of this policy unless we state otherwise in the rider.

SUICIDE

If the insured, whether sane or insane, dies by suicide, within two years from the policy date, our liability will be limited to an amount equal to the premiums paid for this policy.

INCONTESTABILITY

We cannot contest this policy after it has been in force during the lifetime of the insured for two years after the policy date, except for non-payment of premiums.

COLLATERAL ASSIGNMENT

Your policy may be assigned. The assignment must be in writing and filed at our home office. We assume no responsibility for the validity or effect of any assignment of this policy or of any interest in it. Any proceeds which become payable to an assignee will be payable in a single sum. Any claim made by an assignee will be subject to proof of the assignee's interest and the extent of the assignment.

MISSTATEMENT OF AGE OR SEX

If the age or sex of the insured has been misstated, the benefits will be those which the premiums paid would have purchased for the correct age and sex.

BENEFICIARY

When we receive proof satisfactory to us of the insured's death, we will pay the death proceeds of this policy to the beneficiary or beneficiaries who are named in the application for this policy unless you subsequently change the beneficiary. In that event, we will pay the death proceeds to the beneficiary named in your last change of beneficiary request as provided for in this policy.

If a beneficiary dies before the insured, that beneficiary's interest in this policy ends with that beneficiary's death. Only those beneficiaries who survive the insured will be eligible to share in the death proceeds. If no beneficiary survives the insured, we will pay the death proceeds of this policy to your estate.

CHANGE OF OWNER OR BENEFICIARY

If you have reserved the right to change the owner or beneficiary, you can file a written request with us to make such a change. If you have not reserved the right to change the beneficiary, the written consent of the irrevocable beneficiary will be required.

Your written request will not be effective until it is recorded in our home office records. After it has been so recorded, it will take effect as of the date you signed the request. However, if the insured dies before the request has been so recorded, the request will not be effective as to those death proceeds we have paid.

CHANGE OF PLAN

While your policy is in force with no premium in default, you may exchange your policy for another form of policy. Our approval is needed. An additional payment and evidence that the insured is then insurable under our underwriting rules then in effect, may be required.

PREMIUMS

Your first premium is due as of the policy date and must be paid when the application for insurance is completed. All premiums after the First premium are payable on or before the date they are due and must be mailed to us at our home office. If you would like a receipt for a Premium payment we will give you one upon request.

The premiums for your policy are payable for the period shown on page 3 of your policy, or until the prior death of the insured.

PAYMENT INTERVALS

You may pay your premiums at any interval shown on page 3. These premiums are shown as annual (once a year), semi-annual (twice a year), quarterly (four times a year) or monthly (twelve times a year). You may change the frequency of premium payments, subject to our rules in effect at the time of the change, by filing a written request with us at our home office.

GRACE PERIOD

Your policy has a 31-day grace period. This means that if a premium is not paid on or before the date it is due, you may pay that premium during the 31-day period immediately following the due date. Your premium payment, however, must be received in our home office within the 31-day period. The insured's life will continue to be insured during this 31-day period.

If the insured dies during this period, we will deduct a premium for the 31-day grace period from the death proceeds of this policy. This 31-day grace period does not apply to the first premium payment.

The first premium payment must be paid when your application is completed.

NON-PAYMENT OF PREMIUMS

If a premium is not paid by the end of the grace period, the policy will lapse as of the premium due date and be out of force except as provided in the Guaranteed Value Options provision (see page 6).

REINSTATEMENT

If a premium is not paid before the end of the 31-day grace period, your policy will lapse, and no further premium payments may be made.

However, even if your policy lapses, the values provided for in the Guaranteed Value Options section of this policy on page 6 may be available to you. You may also ask us within five years of lapse to restore your policy to a premium paying basis. We will require:

1. Your written request to reinstate this policy.
2. Evidence of insurability satisfactory to us.
3. Payment of any indebtedness.

4. Payment of all past due premiums on your policy, and
5. Payment of interest compounded annually on all past due premiums and any indebtedness. The policy reinstatement interest rate will be the rate shown on page 3.

Our determination of the insured's continued insurability and the payment of all past due premiums with interest must occur during the insured's lifetime. Your policy cannot be reinstated if your policy was placed on extended term insurance and the term period has expired or if your policy was surrendered for cash.

We may contest the reinstatement of this policy until it has been in force during the lifetime of the insured for two years from the date of reinstatement.

YOUR LOAN VALUES

Your policy has two loan privileges:

1. You may borrow the cash value.
2. You may have past due premiums paid by automatic loans.

Loans have priority over the claims of any assignee or other person. Your policy is the sole security for all loans.

POLICY LOANS

You can borrow up to the available loan value of your policy unless your policy is on extended term or reduced paid-up insurance (see below). At Your request, we will send you a loan agreement for your signature. We have the right to postpone your loan for up to six months unless the loan is to be used to pay premiums on any policies you have with us.

The loan value of your policy is its cash value (see page 4) minus any indebtedness. Your cash value will be determined as of the date to which your premiums are paid on this policy, but not beyond the next policy anniversary.

AUTOMATIC PREMIUM LOANS

If you asked for this service in your application, or by later written request, we will automatically make a loan to you to pay any premium not paid by the end of the grace period. Your policy

must be in force and have enough loan value. If there is not enough loan value to pay a premium, the policy will lapse and the Guaranteed Value Options provision will apply (see below).

You can also make written request to tell us you do not want this service.

LOAN INTEREST PROVISION

Policy loans will bear interest at the rate specified on page 3.

If you do not pay the interest on your loan when it is due, the unpaid interest will be added to your loan and charged the same rate of interest as your loan.

INDEBTEDNESS

If indebtedness exceeds the cash value of your policy, we will mail notice to your last known address and that of any assignee of record. If the excess is not paid within 31 days, the policy will terminate.

You may repay all or part of the indebtedness while the insured is alive and no Guaranteed Value Option is in effect.

Any outstanding indebtedness at the time of the insured's death will be deducted from policy proceeds.

GUARANTEED VALUE OPTIONS (Non-Forfeiture Options)

Your policy provides Guaranteed Value Options as shown on page 4. You may elect any available option by writing to us.

A premium may be paid in cash or by an automatic premium loan. If a premium is not paid by the end of the grace period, the paid-up insurance option shall become effective as of the due date of the unpaid premium. However, you will still have the right for two months after that due date to elect one of the Guaranteed Value Options.

PAID-UP INSURANCE OPTION

You may continue your policy as paid-up insurance for a reduced amount, payable under the same conditions as this policy. We will use the cash value to buy paid-up insurance at the net single premium rate for the insured's attained age. If a paid-up policy is surrendered for its cash value within 30 days after a policy anniversary, the cash value will be equal to the cash value on that policy anniversary.

EXTENDED TERM INSURANCE OPTION

If this is a standard premium class policy, you may continue it as term insurance. No further premium will be due. The amount of

the extended Term insurance will be the total of:

- The face amount of this policy
- MINUS • Any indebtedness (see definition, page 2).

The term period begins on the date to which premiums are paid. The cash Value is applied as a net single premium at the insured's attained age to determine the length of the term. For this purpose, the attained age will be the insured's age on the date of the first unpaid premium. If a policy on extended term insurance is surrendered for its cash value within 30 days after a policy anniversary, the cash value will be equal to the cash value on that policy anniversary. If an equal or greater amount of insurance would be provided under the paid-up insurance option, only that option will be available.

CASH VALUE OPTION

You may surrender your policy for its cash value. Your cash value is:

- The cash value of your policy (see page 4)
- MINUS • Any indebtedness

Surrender will be effective on the date of your written request. We may require that your policy be sent in with your written request before making surrender payment.

We may defer payment of any cash value for not more than six months.

When you surrender your policy for its cash value your policy will terminate.

BASIS USED FOR CALCULATIONS

We use the mortality table, and interest rate shown on page 4, to calculate (1) cash values, (2) reserves and (3) net single premiums for paid-up insurance.

All values are at least equal to those required by the law of the

state in which the policy is delivered. We have filed with that state a detailed statement of the method of calculating values.

The values shown on page 4 are for completed policy years. They assume that there is no indebtedness and that premiums are paid to the end of the policy year.

After the policy year in which a value is first shown, the values between any two policy years shown will be determined by interpolation with allowance for the premiums paid for the period between such consecutive years. Values for policy years not shown will be furnished upon request.

The cash value of any paid-up insurance is the net single premium for such insurance at the attained age of the insured.

PAYMENT OF PROCEEDS

The proceeds of this policy will be payable if the policy is surrendered for its cash value (living benefits), or when we receive due proof satisfactory to us of the insured's death (death benefits). These events must occur while the policy is in force. The proceeds will be paid in a single sum unless a settlement option has been selected. We will deduct any indebtedness from the proceeds. All payments by us are payable at our home office. Proof of any claim under this policy must be submitted in writing to our home office.

SETTLEMENT OPTIONS

You may, during the insured's lifetime, request that we pay the proceeds under one of the following settlement options. We will also use any other method of payment that is agreeable to you and us. A settlement option may be selected only if the payments are to be made to a natural person in that person's own right.

OPTION 1--Interest Payments--

(Payment of Interest on the proceeds at such time and for a period that is agreeable to you and us.) Withdrawal of proceeds may be made in amounts of at least \$100. At the end of the period, any remaining proceeds will be paid in either a single sum or under any other method we approve.

OPTION 2--Payments for a Specified Period--

(Monthly payments for a specified number of years) The amount of each monthly payment for each \$1,000 of proceeds applied under this option is shown in the following table. The monthly payments for any period not shown will be furnished upon request.

OPTION 2 TABLE

PAYMENTS FOR A SPECIFIED PERIOD	
Number of Years Payable	Amount of Monthly Payments
5	\$17.91
10	9.61
15	6.87
20	5.51
25	4.71
30	4.18

OPTION 3--Life Income--

(Monthly payments for the life of the person who is to receive the income) We will require satisfactory proof of the person's age and sex. Payments can be guaranteed for 10, 15, or 20 years. The amount of each monthly payment for each \$1,000 of proceeds applied under this option is shown in the following table. The monthly payments for any ages not shown will be furnished upon request.

OPTION 3 TABLE

LIFE INCOME					
MONTHLY INCOME PAYMENTS					
Guaranteed For Life			Guaranteed For For 10 Years		
M	AGE	F	M	AGE	F
\$4.50	50	\$3.98	\$4.41	50	\$3.95
5.09	55	4.44	4.93	55	4.38
5.86	60	5.08	5.56	60	4.95
6.93	65	5.96	6.32	65	5.68
8.43	70	7.22	7.20	70	6.58
Guaranteed For For 15 Years			Guaranteed For For 20 Years		
M	AGE	F	M	AGE	F
\$4.30	50	\$3.90	\$4.14	50	\$3.83
4.73	55	4.30	4.46	55	4.16
5.20	60	4.78	4.77	60	4.52
5.79	65	5.32	5.02	65	4.86
6.14	70	5.87	5.19	70	5.11

OPTION 4--Payments of a Specified Amount--

(Monthly payments of a specified amount until the proceeds and interest are fully paid.)

OPTION 5--Joint and Survivor Life Income--

We will pay the amount retained, with interest, in equal monthly installments during the joint lifetime of two persons and continue them during the lifetime of the survivor. See table below for example. We will furnish the income for other combinations of age or sex, if requested.

OPTION 5 TABLE

JOINT AND SURVIVOR LIFE INCOME				
MONTHLY INSTALLMENTS FOR EACH \$1,000 OF AMOUNT RETAINED				
	AGE OF OTHER PAYEE* (FEMALE)			
	15 Years Less than Male Payee's	10 Years Less than Male Payee's	5 Years Less than Male Payee's	Same as Male Payee's
50	\$3.07	\$3.23	\$3.42	\$3.61
55	3.27	3.48	3.72	3.97
60	3.53	3.80	4.11	4.45
65	3.87	4.23	4.65	5.12
70	4.31	4.80	5.40	6.06
*Age nearest birthday.				

OPTION 6--Alternate Income--

When a type of income option available under Option 2, 3 or 5 is desired, we will automatically pay that type of income under this option if the amount is greater than under Option 2, 3 or 5. The amount of income under this option will be based on actuarial assumptions then being used by us for our single premium immediate annuities. However, there will be a charge for taxes or expenses.

INTEREST FROM DATE OF DEATH

If the proceeds of any benefits under this policy are not paid within thirty days after we receive due proof of the death of the insured (or where required by law within thirty days after the death of the insured), we will pay interest on death benefits from the date of death to the date of payment. The interest rate will be determined by us, but never less than 3%.

CONDITIONS

1. Proceeds of less than \$1,000 may not be applied under any settlement option. We may change the payment frequency if payments under an option become less than \$20.
2. A corporation may receive payments under a life income option only if the payments are based on the life of the insured, or a surviving spouse or dependent of the insured.

If a settlement option is requested, we will prepare an agreement to be signed which will state the terms and conditions under which the payments will be made. This agreement will include a statement regarding the withdrawal value, if any, and to whom any remaining proceeds will be paid following the death of the person receiving the payments.

A beneficiary may select a settlement option only after the insured's death. However, you may provide that the beneficiary will not be permitted to change the settlement option you have selected.

PROCEEDS EXEMPT FROM CLAIM OF CREDITORS

To the extent permitted by law, no payment of proceeds or interest we make will be subject to the claims of any creditors.

Also, if you provide that the option selected cannot be changed after the insured's death, the payments will not be subject to the debts or contracts of the person receiving the payments. If garnishment or any other attachment of the payments is attempted, we will make those payments to a trustee we name. The trustee will apply those payments for the maintenance and support of the person you named to receive the payments.

RATE OF INTEREST

Options 1, 2 and 4 are based on a guaranteed interest rate of 3%. Options 3, 5 and 6 are based on a guaranteed interest rate of 2.5% using the 1949 Annuity Mortality Table.

SUMMARY OF POLICY BENEFITS

LIVING BENEFITS

Your policy has certain guaranteed values which are available to you during your lifetime. These values consist of the cash or loan values. You may use these values:

- To provide retirement income (see page 7).
- As collateral for a loan or as the basis for a policy loan (see page 6)
- To continue some insurance protection if you cannot or do not wish to continue paying premiums (see page 6).
- To obtain cash by surrendering your policy (see page 6).

The available cash or loan value for such users is the total of:

- MINUS
- The cash value of your policy (see page 4)
 - Any indebtedness (see definition page 2)

DEATH BENEFITS

The amount of payment to the beneficiary is the total of the following amounts determined on the date of the insured's death:

- PLUS
- The face amount of this policy (see page 3)
 - Any additional insurance on the insured's life provided by an extra benefit rider (see page 3)
- MINUS
- Any indebtedness (see definition, page 2).

EXTRA BENEFIT RIDERS

The extra benefits, if any, listed on page 3 are fully described in the extra benefit riders that immediately precede the copy of your application.

YOUR RIGHTS

During the insured's lifetime and unless otherwise provided in this policy, you have the exclusive right to assign this policy, to receive every benefit and to exercise every right, privilege and option this policy grants or that we allow. Among your rights are:

- To change the owner or beneficiary. (Change of Owner and Beneficiary, page 5.)
- To surrender this policy. (Cash Value Option, page 6.)
- To stop premium payments but keep part of the face amount in force for the full period of the policy. (Paid-Up Insurance, page 6)
- To change the frequency of premium payments. (Payment Intervals, page 5.)

- To use the loan value of the policy to pay premiums due. (Automatic Premium Loan, Page 6.)
- To borrow on the policy. (Policy Loans, page 6.)
- To reinstate the policy after lapse. (Reinstatement, page 6)
- To receive policy benefits as income. (Settlement Options, page 7)

To exercise any of these rights, or to apply for the proceeds or any benefits under this policy, communicate with our nearest representative or directly with our home office. Please notify us promptly of any change of address.

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■ Please examine your policy and the attached copy of the application carefully. Contact your agent if you desire additional service or information.

■ If you change your address, please notify us at the home office giving your full name and policy number

■ Your policy is a valuable asset. For your own protection, let us advise you regarding any suggestion to terminate or exchange this policy.

WICHITA NATIONAL LIFE INSURANCE COMPANY

Wichita National Building
711 S.W. "D" Avenue
Lawton, Oklahoma 73501
580-353-5776

Level Amount Whole Life Insurance
Level Premiums Payable to Specified Age or Until Prior Death of Insured
Face Amount Payable at Death
Non-Participating

Register of Assignment

NOTE --- Assignment Takes Effect **Only** Upon Endorsement By An Executive Officer Of The Company.

DATE ENDORSED	ASSIGNEE	ENDORSED BY
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